Illinois Early Learning Council

Systems Integration and Alignment Committee's

Health Subcommittee

Proposed Plan for Integrating Health into Early Care and Education Systems

Health Subcommittee Proposed Plan
Table of Contents

Introduction to Recommendations

This report presents the recommendations of the Early Learning Council (ELC) related to the role of Early Care and Education providers in the health and well-being of children in their care, whether in licensed home- or center-based care, early intervention, or home visiting programs. The recommendations are intended for a wide audience, including: state and local agencies responsible for early care and education programs; education, public health, and human services systems; health and early childhood advocates; institutions of higher learning that develop and deliver curricula, educate and prepare early care and education professionals, or provide professional development opportunities for providers; parents and caregivers of young children; and more. The ELC hopes that this report will be useful to those already involved in the early care and education and health sectors as well as those who are new to these areas. For new audiences, the ELC has included a glossary of terms to provide explanations and definitions for terminology that is highly specialized or has specific and unique meaning in the context of early childhood or health.

The ELC also hopes that this set of recommendations advances statewide discussions about the health and well-being of young Illinoisans and the roles that early care and education providers can play in promoting and supporting health among the children in their care. In order to ensure that these recommendations are considered by the appropriate agencies, organizations, or individuals, the ELC recommends that a special task force of the Interagency Team be created to work on implementation of these recommendations with the relevant government partners. The ELC's Health Subcommittee is committed to monitoring the implementation of this proposed plan by all actors identified – governmental and non-governmental alike.

Report Structure

This report is divided into a number of sections. In the remainder of the introduction, the ELC describes the Subcommittee's process and structure, the methods used to develop the plan, a set of general recommendations and cautions that apply to health and wellbeing of young children in general (as opposed to the recommendations in the body of the report, which are presented by health issue area), and concludes with the recommendations from the health issue areas that can be accomplished in the short-term.

The body of the report is comprised of separate sections for specific health issue areas. Each section begins with an introduction to the health issue area and the current advances and gaps in the State of Illinois. Next, recommendations are presented within each section and divided into four types: policy, training, support, and information (these recommendation types are described on page eight). Each section concludes with a list of resources that are currently available and can provide additional information or tools related to the health issue area.

In addition to the recommendations for each health issue, this report includes a number of other items. Several appendices are included to provide further context and

information related to the recommendations. Appendix A is a set of matrices the Health Subcommittee members used to organize and present information on each specific health issue area (matrix development is described in more detail on page seven). Appendix B is the template the subcommittee used to prioritize the health issues for inclusion in the report (the use of the template is described in more detail on page eight). Appendix C is a glossary of terms that will help bridge any disciplinary language and terminology gaps that the committee identified over the course of its work. Appendix D presents the recommendations by type of actor (e.g., state agency, non-governmental organization, etc.) responsible for leading the implementation of the recommendation(s). Appendix E presents the recommendations by category (e.g., policy, training, support, and information; described on page eight) so that specific audiences can identify immediately the recommendations in which they would be most interested (i.e., legislators or state agencies may be most interested in the policy recommendations). Appendix F presents the top priority recommendations that the Subcommittee considered the most important from each health issue.

Subcommittee Background, Process, and Structure

In 2012, the ELC's Systems Integration and Alignment Committee established a Health Subcommittee. The Subcommittee's charge was to develop strategies for 1) integrating health across early childhood systems and 2) addressing gaps in health services that can be addressed by early childhood systems in order to support children's healthy development and school readiness. Health experts from around the state working on issues relevant for young children were invited to participate by the Systems Integration and Alignment Committee Co-Chairs. The Subcommittee first met in July 2012 and created a work plan soon thereafter to guide its efforts. Given its broad charge and the significant number of health issues related to early childhood, the Subcommittee established a set of criteria in February 2013 to guide selection and prioritization of health issues on which it would focus. The criteria were:

1. Sufficient external or internal demand to address the health issue
2. Health issue affects large numbers of children OR has severe impacts on those affected
3. Health Subcommittee member willingness to lead thinking and work on health issue OR clear link to group already working on health issue
4. Sufficient staff support for work on health issue
5. Existence of reasonable best practices from which to draw or examples to follow OR addressing the issue in early childhood would be innovative enough that Illinois would be seen as a leader

The selection of the health issues was also informed by responses to questions developed by the Subcommittee for inclusion in the child care provider survey administered in 2013 by the Illinois Department of Human Services and the Illinois Network of Child Care Resource and Referral Agencies (IDHS/INCCRRA). Each issue was then assigned to one or more members of the Subcommittee to lead a health issue team and to eventually develop a set of recommendations that would strengthen the integration between early childhood and health systems on that particular issue. For the

purposes of the Subcommittee's work and this report, and because as health experts the members of the Subcommittee had varying degrees of experience with or knowledge about early childhood systems, the group used the broad term "early care and education provider" or "ECE provider" to mean any professional whose job is to provide education, intervention, and/or child care services to children ages zero to five, whether in centers or in homes.

In order to standardize the process each health issue team would use and to increase the cohesion of final recommendations, the teams used a matrix created by Subcommittee leadership (see Appendix A) to explore the gaps and opportunities for integration between the ECE and health sectors. Health issue teams invited additional health professionals who were not Subcommittee participants to add more depth and expertise to the discussions as needed. The health issue teams focused their attention on five common contexts where ECE providers intersect with young children and their families: home visiting, center-based licensed child care, home-based licensed child care, license exempt child care, and early intervention programs. The matrix called for the identification of the appropriate roles for professionals in each of the five early childhood contexts in addressing that particular health need among young children. For example, home visitors may be able survey the home environment related to injury prevention and work with families to improve safety (assessment and intervention) while a more appropriate role for center-based child care staff may be to educate families about steps to increase safety in the home (education and information). The groups identified training needs that could strengthen providers' ability to fill the identified roles. Gaps in the early childhood system were also identified (e.g., training, policy, etc).

In addition to the development of matrices by health issue teams, a number of health topics were also assigned to ad hoc work groups for in-depth exploration and/or immediate action. Work groups were established to address obesity, oral health, vision and hearing, and chronic disease and medical homes for children.

Health Issue Review and Prioritization

Between September 2013 and March 2014, the Health Subcommittee reviewed each health issue matrix. Health issue teams presented their work and Subcommittee members suggested revisions. Matrices were finalized by May 2014. The Health Subcommittee then followed a second prioritization process for moving forward the health issues that were to be included in the final recommendations. The criteria for selecting these health issues were:

1. Issue affects many children
2. Issue has a severe impact on children
3. Reasonable (i.e., feasible and scalable) best practice with known successes has been identified to address the issue through the early childhood system
4. Addressing issue through the early childhood system is innovative and would position Illinois as a national leader

5. Addressing issue through the early childhood system is supported by current or emerging state/federal requirements or quality initiatives
6. An organization would be willing to support the implementation of the recommendations for addressing issue (with the necessary stakeholders)
7. Addressing issue through the early childhood system is cost effective/has a good return on investment
8. There would be low implementation barriers (i.e., little to no opposition) in implementing potential recommendations for addressing issue.

The Health Subcommittee members where then asked to rank the health issues by quartile (See Appendix B) for consideration by an ad hoc work group that would draft the final recommendations. The following four health issues were most frequently ranked in the top quartile by participating members: Child Development; Trauma, Child Abuse and Neglect; Parental Mental Health; and Obesity Prevention. Members prioritized health issues related to mental health and child development, obesity, and oral health above all other health issues. However, Subcommittee members felt that the report should be as comprehensive as possible and include most, if not all, of the Subcommittee recommendations. Therefore, this report includes recommendations developed by the Health Subcommittee for all of the issues reviewed.

Development of Final Recommendations

Subcommittee leadership reviewed all of the recommendations proposed by the health issue teams and identified four primary types of strategies. **Policy** recommendations refer to those strategies that require legislative action or action by state agencies representing the Executive Branch of Illinois government. In some cases, policies may be enacted by non-governmental institutions that have wide reach across one or more entire ECE contexts (e.g., INCRRAA). **Training** recommendations refer to strategies that build the skills and competencies of ECE providers to deliver certain services or to take on specific roles related to the health of children in their care. **Support** recommendations refer to strategies that would increase the availability or quality of programs and services that ECE providers could invite into the ECE setting (e.g., oral health screening provided by pediatric dentists). **Information** recommendations refer to strategies that educate families and caregivers of young children (e.g., fact sheets) or raise awareness about an issue or its solutions (e.g., a media story or a public education campaign). During the prioritization process, members identified the types of strategies they thought would be most effective in addressing the health issue. Members of the ad hoc work group charged with drafting this report used those classifications to ensure that a wide variety of strategies were offered so that as broad an audience as possible would find the recommendations useful.

While Subcommittee members put significant effort into the development of these recommendations, they were not created in a vacuum. The Health Subcommittee referred to national and other local recommendations related to the health of young children. Resources referred to include the American Academy of Pediatricians' (AAP) *Caring for our Children* National Health and Safety Performance Standards Guidelines for ECE Programs, First Lady Michelle Obama's *Let's Move!* Campaign's child care

recommendations, the Child and Adult Care Food Program guidelines, the Illinois pre-k expansion grant requirements, the Strong Start Act, proposed regulations for the national Child Care Development Fund, and more. The Subcommittee also agreed that the simultaneous development of an Illinois Early Childhood Mental Health Action Plan by the Irving Harris Foundation in conjunction with the Illinois Children's Mental Health Partnership (ICMHP) and various state agencies, experts, and stakeholders is very much aligned with the work of the Subcommittee and decided that this work would serve as the foundation for Health Subcommittee recommendations around the topics related to social-emotional development and mental health.

Some recommendations have already been delivered to various state agencies because they either requested input (as was the case with obesity prevention and oral health licensing requirements for licensed child care) or because they were already in development when the Subcommittee began its work (as was the case with vision and hearing recommendations).

General Recommendations and Cautions

In addition to the issue-specific recommendations included in this report, the Health Subcommittee has developed several over-arching recommendations and identified general themes to be considered during the review and implementation of these recommendations.

First, the Subcommittee has recognized four specific needs for data gathering and reporting that pertain to the integration of health and early childhood systems:

1.) An unduplicated count of children being served in the system would help both the health and early childhood systems not only monitor children's access to health-related services and identify gaps in services, but would also help the state and non-governmental organizations to understand the scope of needs and opportunities. On a more specific and practical note, the numbers of children served by the system, and thus potentially reached by an intervention, would be an important element of a successful grant proposal to expand or bring new services to Illinois.
2.) An understanding of the number of children served by the early childhood system in Illinois whose family incomes are at or below the federal poverty line would help state agencies, funders, advocacy organizations, and others to monitor indicators that are especially relevant to children living in poverty, such as children's access to health care, exposure to harmful social and environmental conditions, or families using early childhood services who are also receiving supplemental food assistance.
3.) Parties involved in developing the Unified Data System should consider health data as an important component of the system:
    a. The ELC's Data, Research and Evaluation Committee should recommend that developmental, social-emotional and mandated health screenings along with immunization documentation be included in the Unified Early Childhood Data System to help track the administration of screening as well as valuable outcome data.

   b. Other specific data recommendations related to the health issue areas considered in this report are included in the appropriate sections.

4.) Because best practice calls for effective referral and follow-up protocols between healthcare and ECE providers, all ECE providers should have access to the Illinois Statewide Provider Database (SPD)[1] in order to identify and connect to health service providers in their community. This resource is currently underutilized and ECE providers could use it to help make effective referrals on behalf of the children and families they serve and to provide the appropriate follow-up services.

Second, in considering these recommendations, a number of issues must be addressed in terms of their feasibility, sustainability, and impact. For example, new training for providers should not simply be added to the already significant amount of trainings required of ECE providers. Costs incurred by ECE providers should be taken into account and reimbursed or covered where possible. In addition, whenever possible, training should be accredited by the appropriate agency or continuing education credits provided to professionals who need them. These recommendations should be discussed with state agencies, funders, the ECE provider community, and other stakeholders before being fully adopted or implemented. While these sectors were represented in the Subcommittee and thus in its work, the Subcommittee advises broader participation in final decision making.

Finally, individual and community culture are important elements of health-related attitudes and behaviors for children and their families. As such, the committee recommends that cultural and linguistic factors related to each of the health issues covered in this report be considered when making policy or programmatic decisions. These will be particularly important in making sure that policy solutions do not do inadvertent harm, that strategies are relevant and equitable when applied in diverse communities, and that the intended outcomes are achieved. Cultural and linguistic considerations will also be important for strategies that involve direct communications with children and families. In addition to this overall "caution," the committee has included specific cultural and linguistic considerations in individual sections of the report as needed.

<u>Opportunities for Immediate Action</u>

The Subcommittee has identified a number of recommendations from the complete list in this report that it believes can be acted upon immediately, or in short order, due to current momentum in the state, parallel activities currently underway, limited resource needs for implementation, or some combination of the four. These are listed here by health issue:

[1] The Illinois Statewide Provider Database is administered by the Department of Children and Family Services.

Illinois Early Learning Council, Systems Integration and Alignment's Health Subcommittee Proposed Plan

Health Issue	Recommendation
Chronic Health Conditions	The Illinois Department of Public Health (IDPH) should develop medical action plan guides for the Illinois Department of Children and Family Services (DCFS), the Illinois State Board of Education (ISBE), and the Illinois Department of Human Services (IDHS) to distribute to their programs to show parents how to talk to health care providers about action plans and how to communicate with early care and education providers about their children's chronic health needs.
	Gateways to Opportunity should expand the "Welcoming Every Child" training to include more comprehensive information for using action plans to support children with chronic health issues.
Immunizations	The state agencies should distribute information on immunization resources to all early care and education providers that they oversee.
Developmental and Social-Emotional Screening	ISBE, IDHS, and DCFS should distribute the Memoranda of Understanding and resource guide developed by the Special Education Subcommittee to all early care and education programs and make it available in all trainings on developmental and social-emotional screening.
Obesity Prevention	DCFS should update Rule 406 to align with the nutrition, physical activity and screen time standards in Rule 407.
Oral Health	The Illinois Department of Healthcare and Family Services (HFS), IDHS, and ISBE should partner with the Illinois Network of Child Care Resource and Referral Agencies (INCCRRA) to promote regular dissemination to early care and education staff of an up-to-date health provider list that includes 1) pediatric dentists and 2) primary care physicians that have been trained through *Bright Smiles from Birth*.
Parental Depression	HFS should disseminate a list of behavioral health services available through Medicaid, including instructions for accessing these services, to the state agencies for dissemination to all early care and education providers.
Physical Health Screening: Lead	IDPH should develop and distribute materials to all early care and education providers explaining the signs of lead presence in the home as well as early symptoms of lead exposure.
Physical Health Screening: Vision	IDPH should establish an additional certification and recertification option for technicians to conduct vision screenings for children ages three to five only.
	IDPH should develop training for early care and education providers on the state vision screening mandates and disseminate this training through IDHS and ISBE, along with INCCRRA.
Physical Health Screening: Hearing	IDPH should partner with the Illinois EHDI program and its ECHO Initiative to develop a standardized hearing screening protocol for early care and education programs serving children ages zero to three years.
SIDS, SBS, and Product Safety	DCFS should link directly with the Consumer Product Safety Commission's recall list so that it is always complete and accurate and DCFS should require licensed providers to sign up for alerts from the CPSC.
Trauma, Child Abuse & Neglect, and Domestic Violence	DCFS should provide early care and education providers with automatic access to the SPD of service agencies and programs throughout Illinois so that providers can locate mental health resources in their communities to support young children and families.

In addition to the recommendations from the report that are presented above, some additional recommendations may be easier to implement than others. For example,

policy and information recommendations may require minimal, if any financial resources while training and support recommendations may require the development of new curricula or programs – thus requiring more financial resources and more time. Some may be on the verge of implementation already because they are being considered in parallel processes or conversations across the state or by state agencies. The Subcommittee has organized the recommendations in several ways (e.g, by actor, by category, by top priority) to facilitate their review by specific agencies, organizations, or professional organizations. While these recommendations are not intended to be exhaustive and the Subcommittee acknowledges that there may be other health issues to consider that were not included in this work, these recommendations represent the efforts of many health and early childhood experts with vast knowledge about the particular health issues to which they were assigned.

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SECTION ONE:

Recommendations for Chronic Health Conditions and Immunizations

Introduction to Issue: Chronic Health Conditions

Currently in the United States, between 15-20% of children are affected by one or more chronic medical conditions.[2,3] The state of Illinois has taken action to establish laws, rules, resources, and protections to help schools respond to children's health care needs in grades K-12. These standards, however, do not reach our youngest and most vulnerable population: children under the age of five. Gaps in policy, training, and disseminated information affect children's health in multiple areas, including management of chronic health conditions like asthma and diabetes, regular medical examinations for children in any early care and education system, and access to medical homes or primary care physicians (including other medical providers) for families.

Currently, center-based early care and education programs in Illinois must have written "provision[s] for emergency medical care, treatment of illness and accidents."[4] These provisions, however, do not outline a plan for the most likely emergencies in an early care setting—emergencies involving students with chronic health conditions. As a result, an early care and education provider, for example, may not feel equipped to either enroll or continue to serve a child diagnosed with diabetes or another chronic health condition.

An easy way to address this need is through the use of medical action plans, which allow physicians and families to collaborate on everyday steps to manage a child's chronic illness as well as emergency situations (see Appendix H, "General Medical Action Plan"). Early care and education providers do not have the expertise or authority to make medical decisions for a child, and medical action plans ensure that early care and education providers handle children's chronic health conditions and special health care needs in a manner approved by the child's medical provider and family. This modest step would help families feel more comfortable accessing early childhood care and services if they knew exactly how their young child's chronic illness or other health condition would be managed in an early care and education setting. Likewise, use of medical action plans will mean that early care and education providers will have specific instructions that leave less room for error and will build their confidence to care for children with special needs.

More broadly, requiring a general "Medical Report" be developed and provided to families (for voluntary completion) in early care and education systems for all children entering care and updated yearly (along with the medical action plan where necessary for children with chronic health needs) would provide context for early care and education programs and promote individualized care (see Appendix G, sample "Medical Report"). A medical report can capture details in a variety of areas including medical history, chronic health conditions, allergy information, possible trauma exposure, and

[2] "Students with Chronic Illness: Guidance for Families, Schools, and Students." *Journal of School Nursing* 73.4 (2003): 131-132.
[3] American Academy of Pediatrics, Council on Children with Disabilities. "Care Coordination in the Medical Home; Integrating Health and Related Systems of Care for Children With Special Health Care Needs." *Pediatrics* 116.5 (2005): 1238-1244.
[4] Ill. Adm. Code ch. 89, §407.250(c)(9). Enrollment and Discharge Procedures. 22 March 2010.

mental health resources, as well as any other information families are willing to share with providers.

Parents do not always realize the importance of communicating relevant health information with early care and education providers. Having parents complete a medical report can open the door to ensure that appropriate supports are provided.

For example, when a child with asthma is first identified through the use of a medical report, the early care and education provider can work with the family to help the child obtain a medical action plan (developed by the child's medical provider and family). A medical action plan for a child with asthma would provide details regarding symptom recognition, trigger identification and control, proper medication administration, and emergency protocols (see Appendix I, sample "Asthma Action Plan"). Another child with asthma might experience different triggers or use a different control, so an individualized document prevents improper or possibly even dangerous treatment by early care and education providers.

In addition to obtaining yearly medical reports completed by parents and children's medical action plans (where necessary), early care and education providers need background knowledge of chronic health conditions common in young children before these children enroll. ISBE recommends that all school staff receive training in recognizing symptoms of allergic reactions, preventing exposure to allergens, appropriate emergency response, how to administer an EpiPen, and response to students with both known and unknown allergies.[5] These recommendations should be equally applicable to early care and education systems, since many allergic reactions occur for the first time in settings outside the home. Additionally, early care and education providers should receive broader training on the use of medical action plans and understanding of the most commonly diagnosed chronic health conditions. Appropriate training allows all providers to partner effectively with families to ensure each child's safety away from home.

It is important to highlight that a child's health needs can change dramatically while enrolled in an early care and education program, and even healthy children can develop chronic health conditions at a young age. HS programs in Illinois require annual health examinations in accordance with state EPSDT program schedules.[6] Illinois' Medicaid EPSDT program concurs with the AAP's recommendations of annual health examinations for children ages three to six.[7] Currently, DCFS Licensing Standards state that a child's medical examination form is valid at center-based[8] and home-based[9] early

[5] *Guidelines for Managing Life-threatening Food Allergies in Illinois Schools.* Illinois State Board of Education, Illinois Department of Health, 2010. <http://www.isbe.state.il.us/nutrition/pdf/food_allergy_guidelines.pdf>.

[6] Head Start Performance Standards, 45 CFR §1304.20(a)(1)(ii). Child health and developmental services. 2006.

[7] *Handbook for Providers of Healthcare Services: Chapter HK-200 Policy and Procedures for Preventative Health Care for All Kids*. Illinois Department of Healthcare and Family Services, 2008. <http://www.hfs.illinois.gov/assets/hk200.pdf>.

[8] Ill. Adm. Code ch.89, §407.310(a)(3). Health Requirements for Children. 1 August 2014.

[9] Ill. Adm. Code ch.89, §406.14(c)(1). Health, Medical Care and Safety. 13 November 2006.

care and education programs for two years, with an initial form dated less than six months prior to enrollment. School-based early care and education programs are only recommended to update this information every two years, and have no legal obligation to request anything more than an initial health examination upon enrollment.[10] Updating health examinations **annually** would provide a reliable record of possible chronic health conditions, allergies, or other areas of medical concern.

Early care and education programs can also ensure appropriate care for all children, with or without chronic health conditions, if providers have access to a physician familiar with the child's medical history. Primary care physicians (and other medical providers) and medical homes ensure open communication between medical providers and families, and support comprehensive medical care for children. Currently, there are no standards for communication between early care and education programs and a child's medical home or primary care physician, and no required trainings to help early care and education providers to facilitate this connection. If providers actively communicated with medical providers, they could collaborate in serving families through shared information, more streamlined access to documentation, and timely preventative services for children. Families are more likely to seek out comprehensive treatment, screenings, immunizations, and other preventative services when they have an established primary care provider or medical home.

All of the following recommendations encourage parents to become actively connected to a primary care provider as a critical component of their child's health. Accordingly, it is also important for families to have access to health insurance.

Recommendations (Policy, Training, and Information): Chronic Health Conditions

POLICY:

1. DCFS should extend 89 Illinois Administrative Code §407.250(c)(9)[11] to require that all child care providers keep an updated medical action plan on file for any child with a chronic illness. IDHS should extend this to all early care and education systems including EI and home visiting programs. ISBE should extend this requirement to all early care and education programs they regulate.

2. IDPH should amend the Illinois Child Health Examination Code §665.140(e)[12] for school-based child care and DCFS should amend the Licensing Standards for centers §407.310(a)(3)[13] and home-based child care §406.14(c)(1)[14] to require that center-, home-, and school-based early care and education programs update each child's Certificate of Health Examination annually.

[10] Ill. Adm. Code ch.77, §655.140(e). Timetable for Examinations. 11 May 2009.
[11] Ill. Adm. Code ch.89, §407.250(c)(9). Enrollment and Discharge Procedures. 22 March 2010.
[12] Ill. Adm. Code ch,77, §655.140(e). Timetable for Examinations. 11 May 2009.
[13] Ill. Adm. Code ch.89, §407.310(a)(3). Health Requirements for Children. 1 August 2014.
[14] Ill. Adm. Code ch.89, §406.14(c)(1). Health, Medical Care and Safety. 13 November 2006.

3. IDPH should amend the Illinois Child Health Examination Code §665.140(e)[15] for school-based child care and DCFS should amend Licensing Standards for centers §407.310(a)(3)[16] and home-based child care §406.14(c)(1)[17] to require that all early care and education systems provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms. IDHS and ISBE should extend this requirement to all early care and education systems, including EI and home visiting programs. Where needed, these programs should also provide families with a "general medical action plan" for children with chronic health needs to complete with their medical provider (Appendix G, sample "Medical Report" and Appendix H, sample "General Medical Action Plan").

4. ISBE should consider amending the Care of Students with Diabetes Act 105 ILCS 145/10 and DCFS should amend the Licensing Standards for centers §407.310(a)(3)[18] to extend application of the Diabetes Care Act requirements to center and school-based programs. The Diabetes Care Act currently applies only to children in primary, secondary, charter, or private schools.

5. ISBE should consider amending the undesignated epinephrine auto-injector provisions in 105 ILCS 5/22-30 and DCFS should amend the Licensing Standards for centers §407.310(a)(3)[19] and home-based child care §406.14(c)(1)[20] to allow certain early care and education settings to stock undesignated epinephrine auto-injectors.

TRAINING:

1. Gateways to Opportunity should expand the "Welcoming Each and Every Child"[21] training to include more comprehensive information for using action plans to support children with chronic health issues.

2. DCFS and IDHS should provide early care and education providers with training in the use of action plans, identifying the first signs of allergic reactions or chronic health issues and communicating sensitively to parents about common chronic health issues and appropriate follow-up care.

3. ISBE should make available a delegated care aide (105 ILCS 145/25) training for all early care and education providers serving children with diabetes and additionally offer training on use of an EpiPen.

[15] Ill. Adm. Code ch.77, §655.140(e). Timetable for Examinations. 11 May 2009.
[16] Ill. Adm. Code ch 89, §407.310(a)(3). Health Requirements for Children. 1 August 2014.
[17] Ill. Adm. Code ch 89, §406.14(c)(1). Health, Medical Care and Safety. 13 November 2006.
[18] Ill. Adm. Code ch 89, §407.310(a)(3). Health Requirements for Children. 1 August 2014.
[19] Ibid.
[20] Ill. Adm. Code ch 89, §406.14(c)(1). Health, Medical Care and Safety. 13 November 2006
[21] This training provides information on caring for children with special needs in typical child care settings and aims to increase the knowledge and comfort level of participants to enhance their ability to care for young children with disabilities in early childhood environments.

INFORMATION:

1. IDPH should develop medical action plan guides for DCFS, ISBE, and IDHS to distribute to their programs to show parents how to talk to health care providers about action plans and how to communicate with early care and education providers about their children's chronic health needs.

2. HFS should develop and provide information regarding primary care, medical home, and insurance coverage options to DCFS, IDHS, ISBE, and OECD to disseminate to families with young children in early care and education programs.

Existing Resources: Chronic Health Conditions

1. The AAP publishes reference guides on *Managing Infectious Diseases in Child Care and Schools* and *Managing Chronic Health Needs in Child Care and Schools*. These resources can be purchased at: http://shop.aap.org/publications/books/

2. Insurance:
    a. EverThrive offers free trainings on insurance coverage to providers and families: http://www.ilmaternal.org/hcr/index.html
    b. Get Covered Illinois, Illinois' health insurance marketplace: http://www.GetCoveredIllinois.gov
    c. The Application for Benefits Eligibility (ABE), Illinois' online application system for Medicaid, Supplemental Nutrition Assistance Program (SNAP), and cash benefits: http://www.abe.illinois.gov/

3. Asthma:
    a. Respiratory Health Association, located in Chicago, IL, offers Fight Asthma Now (FAN), a free asthma management program for children and teens: http://www.lungchiago.org

4. Diabetes:
    a. American Diabetes Association: http://www.diabetes.org/childcare
    b. Diabetes Management in the Child Care Setting: http://care.diabetesjournals.org/content/37/10/2834
    c. Children with Diabetes in the Child Care Setting: http://www.diabetes.org/assets/pdfs/advocacy/safe-at-school/children-with-diabetes.pdf
    d. Diabetes Medical Management Plan: http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/written-care-plans/diabetes-medical-management.html

5. Sickle Cell:
    a. Sickle Cell Disease Association of Illinois: http://www.sicklecelldisease-illinois.org

6. Epilepsy:
    a. Epilepsy Foundation of North/Central Illinois, Iowa, and Nebraska: http://www.efncil.org/
    b. Epilepsy Foundation of Greater Southern Illinois: http://www.efgreatersil.org/
    c. Epilepsy Foundation of Greater Chicago: http://www.epilepsychicago.org

7. The Special Needs Add-On administered by IDHS provides a 20% add-on to the standard subsidized rate available through CCAP. To apply for the add-on, families must be income eligible and have a child(ren) with a special need/disability as documented by the child's IEP or IFSP. Funds can be used, for example, for purchasing adaptive equipment, securing specialized training for staff, and one-on-one aide for the child: http://www.epilepsychicago.org

Introduction to Issue: Immunizations

There are 14 serious diseases that young children can be protected from with the help of immunizations. Newborn babies are immune to many diseases because they have antibodies they receive from their mothers. However, this immunity goes away during the first year of life. Parents' awareness of vaccine preventable diseases and adhering to the childhood immunization schedules recommended by the CDC remain essential components for reducing infectious disease transmission.

In Illinois, immunizations are required for child care programs below kindergarten, which include nursery schools, preschool programs, early childhood programs, and HS. "Upon first entering a child care facility, all children two months of age and older shall show proof that the child has been immunized, or is in the process of being immunized, according to the recommended schedule, against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, Haemophilus influenzae type b, hepatitis B, varicella, and invasive pneumococcal disease".[22] Due to state requirements, there is potentially a gap between when children enter child care programs and when their next health examination is required.

The majority of vaccine preventable diseases require multiple doses of vaccines before a child is fully protected. Unfortunately, immunization data indicate a progressive downward trend with each additional dose. This trend can have grave implications because it suggests that a large percentage of young children remain unprotected against very serious, sometimes fatal, illnesses. In addition, it means that subsequent doses are then delayed. Delays in doses are especially evident in vaccines requiring doses after age one, such as DTaP (diphtheria, tetanus, and acellular pertussis) and PCV (pneumococcal conjugate vaccine), which have lower completion rates than vaccines requiring fewer doses. As an example, in 2013 87.3% of three-month-olds in Illinois had received the first dose of DTaP. By seven months of age (or the third dose), this percentage dropped to 74.8%, and only about 68.6% of children 18 months of age had received their fourth DTaP.[23]

Communities with pockets of unvaccinated or under-vaccinated populations are at increased risk for outbreaks that could be prevented. Vaccines are recommended at certain ages and intervals to optimize the immune response and ensure protection when a child is most at risk for disease. Following the recommended schedule ensures children have protection against vaccine preventable diseases and are routinely being seen by a medical provider. The goals of the well-child visits are detecting disease, counseling to prevent injury and future health problems, and promoting health (including immunizations, a core component of primary care).

Immunizing children can also help to protect the health of the community, especially children who are too young to be vaccinated, those who cannot receive certain vaccines

[22] Ill. Adm. Code ch.77, §695.10(b). Basic Immunization. 26 August 2014.

[23] *National Immunization Survey – Children 19-35 months*. Centers for Disease Control and Prevention, 2013. <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/>.

for medical reasons, and the small percentage of people who do not respond to a particular vaccine. Vaccine preventable diseases have a costly impact, resulting in doctor's visits, hospitalizations, and premature deaths.[24]

Recommendations (Policy, Training, and Information): Immunizations

POLICY:

1. IDPH should amend the Illinois Child Health Examination Code §665.140(e)[25] for school-based programs administered by ISBE as well as DCFS amendments to the Licensing Standards for centers §407.310(a)(3)[26] and home-based child care §406.14(c)(1)[27] to require that center-, home-, and school-based early care, education and intervention programs update each child's Certificate of Health Examination annually.

2. The ELC's Data, Research and Evaluation Committee should recommend that immunization documentation be included in the Unified Early Childhood Data System.

TRAINING:

1. IDHS and HFS should ensure that all program staff, but particularly family support staff and early childhood staff, have knowledge of the importance of establishing a medical home and accessing immunizations, as well as adhering to the CDC's recommended immunization schedule for young children.

INFORMATION:

1. IDHS, ISBE, and HFS should distribute information about the IDPH's immunization information number (800-526-4372) to all families.

2. IDPH should provide information about immunizations and where to get immunizations for families with young children to state agencies for dissemination to all early care and education providers. This resource should be available to both staff and families.

3. IDHS and ISBE should provide information regarding primary care and medical home options for families with young children.

[24] *Why are Childhood Vaccines so Important?*. Centers for Disease Control and Prevention, May 2014. <http://www.cdc.gov/vaccines/vac-gen/howvpd.htm#why>.
[25] Ill. Adm. Code ch 77, §665.140(e). Timetable for Examinations. 11 May 2009.
[26] Ill. Adm. Code ch. 89, §407.310 (a)(3). Health Requirements for Children. 1 August 2014.
[27] Ill. Adm. Code ch. 89, §406.14 (c)(1). Health, Medical Care and Safety. 13 November 2006.

Existing Resources: Immunizations

1. Existing committees such as the Immunization Advisory Committee help to provide guidance to IDPH on immunization guidelines and policies in Illinois.

2. Illinois' Administrative Code Title 77, Chapter 1, Part 695 Immunization Code requires immunizations for children entering a child care facility or school program:
www.ilga.gov/commission/jcar/admincode/077/07700695sections.html

3. The Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE) allows for staff at child care centers and schools to have read-only access to immunization records entered into the registry by health care providers.

4. EverThrive Illinois provides community-based outreach and education on immunizations to early care and education providers and families through toolkit trainings, print products, and seminars:
http://www.everthrive.org

5. The CDC provides resources on immunization schedules, recommendations and guidelines, and free resources, including print products and media tools:
http://www.cdc.gov/vaccine

6. The AAP provides information to parents on how to prepare for a visit to the pediatrician, what to expect during and after an immunization visit, and resources on vaccine safety:
http://www2.aap.org/immunization/

7. *Vaccinate Your Baby,* a program of Every Child By Two, provides resources to parents on the importance of immunizing on time, every time:
http://www.vaccinateyourbaby.org

8. The Immunization Action Coalition provides easy to read handouts on immunizations and Vaccine Information Statements in various languages:
http://www.immunize.org

9. The Vaccine Education Center by the Children's Hospital of Philadelphia provides parents with up-to-date immunization information and answers to questions about immunizations:
http://vec.chop.edu/service/vaccine-education-center/

10. US DHHS provides basic information about immunizations and the diseases that can be prevented:
http://www.vaccines.gov

SECTION TWO:

Recommendations for Developmental and Social-Emotional Screening

Recommendations for Developmental and Social-Emotional Screening

Introduction to Issue

Early detection of developmental delays, including social and emotional delays[28], leads to early provision of services that are essential for making sure the developmental foundation is strong and that children are healthy and thrive. Without early identification and intervention children may require longer and more expensive interventions and special education that could have been ameliorated or even prevented.

Feasible and scalable practices and tools for developmental screening, including social-emotional screening, are already in place throughout many parts of the Illinois early care and education system. Developmental screening tools should cover the major domains of development: speech/language, cognition, motor/physical, and social-emotional. Delays in social-emotional development, however, are often more subtle and difficult to pinpoint within these comprehensive screening tools even though they contain a few items targeting the social-emotional domain. Thus, best practice has included a targeted screen for social-emotional concerns and delays. The availability of a mental health consultant can assist programs who identify children with social-emotional concerns to adjust practices that will support these children and to find resources if necessary.

While developmental screening occurs in many early care and education programs, screening for social-emotional delays lags behind. HS and EHS programs require a social-emotional screening along with a developmental screening within the first 45 days of enrollment. All evidence-based home visiting programs in Illinois are required to do a social-emotional screening in addition to a developmental screening. Currently, school-based PFA and PI programs require developmental screening, but not social-emotional screening. ExceleRate includes developmental screening at the Silver level, but not social-emotional screening. Similarly, numerous trainings for developmental screening are widely available, but training for social-emotional screening is not as widely available.

Several current initiatives and recommendations are including both developmental and social-emotional screening on a regular and frequent basis in early care and education programs[29],[30]. Illinois is also currently seeking a Medicaid waiver that would reimburse home visits and include administration of a developmental and social-emotional

[28] The term "behavioral health" concerns and screenings is often used interchangeably with "social-emotional" concerns and screenings, including in these recommendations. Screenings identify potential delays and identify the need for further evaluation.

[29] The Handbook for Providers of Healthy Kids Services recommends periodic developmental and social-emotional screening; the recommendations from GOHIT propose that all well-child visits include behavioral health screening; the Pre-K expansion grants require both developmental and social-emotional screening; and developmental and social-emotional screening is proposed in the state indicator data dashboard.

[30] A recently released document from the Administration for Children and Families, *CFOC Basics*, outlines a set of voluntary minimum health and safety guidance for early care and education programs that includes monitoring children for developmental and behavioral health issues and training/orientation to new staff members on typical and atypical development.

screening. Exploration into building on that waiver, if successful, could be explored for all early education and care providers.

Developmental and social-emotional screenings are the first step to ensure children receive the services and resources necessary for healthy development. Tracking the administration of developmental and social-emotional screening can detect children or groups of children who may be falling through the cracks and can also detect if children are getting unneeded multiple screens. However, current tracking efforts are not fully implemented across all early childhood systems or, in the case of social-emotional screening, are non-existent. ICAAP has developed guidelines for referral within the healthcare sector; however, guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers are lacking and need to be developed, incorporated into training, and disseminated to early care and education providers.

Early care and education programs and interventions play a key role in identifying concerns and delays, referring families to appropriate services and supports and supporting children with delays in their various programs. Social-emotional screening should be required for PFA and PI programs. Both developmental and social-emotional screening should be required at all levels of ExceleRate. Such requirements would create a solid system in Illinois for screening all infants, toddlers, and preschoolers for developmental and social-emotional delays.

The following recommendations are offered in support of wider use of screening and best practices for screening. Developmental and social-emotional screening is particularly sensitive to cultural and language differences and needs to be considered in all of the recommendations below:

Recommendations (Policy, Training, Support and Information)

POLICY:

1. IDHS, ISBE, DCFS, HFS and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should require social-emotional screening in programs that currently require regular developmental screening.

2. All early care and education programs and interventions funded through ISBE and IDHS should administer developmental and social-emotional screening where feasible or help ensure that children are screened through Child Find[31] or pediatricians through information and support to parents.

3. IDHS, ISBE, DCFS, HFS and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and

[31] Child Find is the ongoing process through which all children, from birth through 21, are identified, located, and evaluated by each local school district.

education services and are not Medicaid providers should explore the possibility of Medicaid reimbursement for developmental and social-emotional screening.[32]

4. ICMHP and the ELC should develop guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.

5. ISBE should issue guidance to LEAs, CFCs, and early care and education programs on best practice Child Find activities that include monthly Child Find opportunities, social-emotional screening, and utilization of the MOU and screening resource guide developed by the Special Education Subcommittee of the Systems Integration and Alignment Subcommittee of the ELC.

6. Licensing standards for child care through DCFS should require developmental (including social-emotional screening) in both 406 licensing standards for licensed family child care providers and 407 licensing standards for center based child care providers.

7. The ELC's Data, Research and Evaluation Committee should recommend that developmental and social-emotional screenings be included in the Unified Early Childhood Data System to help track the administration of developmental and social-emotional screening.

TRAINING:

1. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or program that provide early care and education services should offer training on social-emotional screening as regularly as training on developmental screening to early care and education providers and Child Find screening teams.

2. ISBE, IDHS, and DCFS should ensure that all training on developmental and social-emotional screening includes how to talk with parents about concerns and delays and how to use the MOUs and resource guide developed by the Special Education Subcommittee as well as how to use guidelines (when developed) on best practices for referral, feedback, and lines of communication.

SUPPORT:

1. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should ensure that mental health consultation is available to and accessed regularly by all early care and education program staff. This recommendation will require the expansion of mental health consultation in all

[32] Current Medicaid providers can bill and receive payment for most widely used developmental and social-emotional screens.

evidence-based intensive home visiting programs, all birth to three and preschool center-based programs, EI, child welfare, and child care programs.

INFORMATION:

1. ISBE, IDHS, and DCFS should distribute the MOUs and resource guide developed by the Special Education Subcommittee to all early care and education programs and make it available in all trainings on developmental and social-emotional screening.

2. When they are developed, ISBE, IDHS, and DCFS should disseminate guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.

3. ISBE, IDHS, and DCFS should ensure that handbooks and guidelines for parents that outline parent's rights and program responsibilities are updated when needed, widely distributed to early care and education programs and available at all trainings on developmental and social-emotional screening.

4. ISBE, IDHS, and DCFS should ensure the links on their websites to handbooks and guidelines for parents are visible and easily found.

Existing Resources

1. Illinois' ExceleRate seeks to expand developmental screening in early childhood programs through achievement of Silver and Gold Circles of Quality.

2. The Special Education Subcommittee of the Systems Integration and Alignment Subcommittee of the ELC has developed the MOUs and resource guide, which are now approved and owned by the agencies and ExceleRate and will be disseminated to programs.

3. There are some current trainings available on developmental and social-emotional screening through Gateways, ICAAP, and the Ounce Institute:
    a. http://www.ilgateways.com
    b. http://www.icaap.knowledgedirectweb.com
    c. http://ounceofprevention.org

4. Infant Toddler Specialists are available through all CCR&Rs and can assist programs with developmental and social-emotional screening.

5. ICAAP, IDHS, and HFS are finalizing a Toolkit for healthcare and early care and education service providers that includes complete information on how to initiate a referral to EI and receive feedback. The Standardized Illinois Early Intervention Referral Forms are available at:
http://www.illinoisaap.org and
http://www2.illinois.gov/hfs/SiteCollectionDocuments/hfs650.pdf

6. Pathways Awareness has materials for parents and professionals about child development and offers classes:
   http://www.pathways.org

7. The Illinois Early Learning Project has free resources, tip sheets, videos, and more available in many languages. Topics include social-emotional development, challenging behavior, etc:
   http://illinoisearlylearning.org/resources/index.htm

8. The Center on the Social Emotional Foundations of Early Learning (CSEFEL) focuses on promoting the social emotional development and school readiness of young children birth to age five:
   http://csefel.vanderbilt.edu

9. Georgetown University Center for Child and Human Development has many resources on early childhood mental health, systems-building, and more:
   http://gucchd.georgetown.edu/64271.html

SECTION THREE:

Recommendations for Obesity Prevention

Recommendations for Obesity Prevention

Introduction to Issue

Researchers have predicted that for the first time in human history, the current generation of children will live shorter lives than the preceding generation because of the negative health effects of obesity.[33] Childhood obesity is related to a plethora of health issues, including: type 2 diabetes, high blood pressure, liver disease, and asthma. Obese children often experience dermatological problems, have trouble sleeping because of obstructed breathing disorders, and face musculoskeletal problems as they grow. Obese children are more likely to have academic problems related to absenteeism which can be exacerbated because of the emotional effects of bullying and depression. Childhood obesity results in an economic burden as well, including $14.1 billion in obesity-related direct medical costs annually nationwide[34]. Children who are obese are more likely to be obese as adults and therefore at higher risk for cardiovascular disease, certain cancers, and premature death[3]. On average, adult obesity costs the U.S. $270 billion a year and Illinois $3.4 billion a year[35,36]. Recent research suggests that prevention efforts should begin as early as pregnancy,[37] that attention should be paid to weight gain even in the first six months of life,[38] and that weight status in early childhood is highly predictive of weight beyond the age of five, throughout childhood, and into adulthood.[39]

Since the 1970s, obesity rates among preschool-age children has more than doubled – from 5% to 12% by 2009; with an additional 27% being overweight.[40] In Illinois in 2011, 14.7% of low-income two to four year olds were obese, with only 10 states having a higher rate[41]. Despite this long-standing increase in rates across the U.S., there is recent evidence to suggest that childhood obesity rates across the U.S. are declining. The CDC has reported a steady decline among two to five year-olds from 13.9% in 2003-2004 to

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[33] Olshansky S. Jay, et al. "A Potential Decline in Life Expectancy in the United States in the 21st Century." *New England Journal of Medicine* 352.11 (2005): 1138-1145.

[34] Trasande L. and Chatterjee S. "The Impact of Obesity on Health Service Utilization and Costs on Childhood." *Obesity (Silver Spring)* 17.7 (2009): 1749-1754.

[35] *Illinois Strategic Plan: Promoting Healthy Eating and Physical Activity to Prevent and Control Obesity 2007 – 2013*. Illinois Department of Public Health, Nov 2007. <http://www.idph.state.il.us/HealthWellness/IL_Existing_State_Plan.pdf>

[36] Behan, Donald F. and Samuel H. Cox. *Obesity and its Relation to Mortality and Morbidity Costs*. Society of Actuaries, Committee on Life Insurance Research, Dec 2010. <http://www.soa.org/Files/Research/Projects/research-2011-obesity-relation-mortality.pdf>

[37] Whitaker, Robert C. "Predicting Preschooler Obesity at Birth: The Role of Maternal Obesity in Early Pregnancy." *Pediatrics* 114.1 (2004): e29-e36.

[38] Taveras, Elsie M. et al. "Weight Status in the First 6 Months of Life and Obesity at 3 Years of Age." *Pediatrics* 123.4 (2009): 1177-1183.

[39] Cunningham, Solveig A. et al. "Incidence of Childhood Obesity in the United States." *New England Journal of Medicine* 370 (2014): 403-411.

[40] "Overweight" among children is defined as having a body mass index (BMI) in the 85th – 95th percentile for children of the same sex and age. "Obesity" is defined as having a BMI above the 95th percentile.

[41] Pediatric Nutrition Surveillance Survey. "Obesity Among 2- to 4-Year-Olds from Low-Income Families, 1989-2011." *The State of Obesity, Better Policies for a Healthier America*. Trust for America's Health and the Robert Wood Johnson Foundation. <http://stateofobesity.org/children24/>.

8.4% in 2011-2012[42]. While this trend is encouraging, rates are still alarmingly high. In addition, racial and ethnic disparities in obesity persist. Children at highest risk are not experiencing the same downward trends. Solutions to obesity must include comprehensive efforts to improve nutrition in early childhood and beyond, including an emphasis on breastfeeding[43].

Efforts should be made to restrict children's exposure to marketing of foods and beverages that are low in nutritional value and high in sugar and fat content. Infants and toddlers must develop the gross and fine motor skills they will need to be able to integrate physical activity successfully into their lives as they age. Data suggests that physical activity among children drops significantly in middle school, especially among girls[44]. Prevention of such declines should begin in a child's early years. In addition to increasing physical activity, an emphasis must be placed on reducing sedentary behaviors.

Researchers have pointed to early childhood programs, and specifically child care, as a promising context for intervention to prevent obesity.[45] Other programs that serve the early childhood population and their families (e.g., EI and home visiting) have the potential to raise awareness about the issue, provide guidance to families and caregivers, and create environments that support health for young children. Children spend a significant number of hours in a child care setting and it is extremely difficult for parents to identify obesity prevention elements when choosing care for their child.

Recent changes at the state policy level, however, position Illinois as a national leader of efforts to intervene on obesity in early childhood. In collaboration with the Health Subcommittee of the ELC's Systems Integration and Alignment Committee, DCFS and the Illinois Joint Commission on Administrative Rules published changes to Administrative Code Title 89, Chapter III, Subchapter E, Part 407: Licensing Standards for Day Care Centers. These changes include tremendous improvements related to childhood obesity prevention in licensed child care centers across the state of Illinois. New licensing requirements, which went into effect on August 1, 2014, establish best practice standards for prevention of childhood obesity by increasing physical activity, reducing passive screen time, and limiting unhealthy food choices. The new requirements also make improvements to breastfeeding support for breastfeeding women whose children are in licensed child care. While this policy change is a major accomplishment, more work is needed to promote the successful implementation of this rule change in licensed child care, to extend such improvements to licensed family child care homes and license-exempt providers, and to support other early childhood

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[42] *Childhood Obesity Facts, Prevalence of Childhood Obesity in the United States, 2011-2012*. Centers for Disease Control and Prevention, Sept 2014. <http://www.cdc.gov/obesity/data/childhood.html>.

[43] White House Task Force on Childhood Obesity Report to the President. *Solving the Problem of Childhood Obesity within a Generation*. Executive Office of the President of the United States, May 2010. <http://www.letsmove.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf>

[44] Ibid.

[45] Kaphingst, Karen M. and Mary Story. "Child Care as an Untapped Setting for Obesity Prevention: State Child Care Licensing Regulation Related to Nutrition, Physical Activity, and Media use for Preschool-Aged Children in the United States." *Preventing Chronic Disease* 6.1 (2009): A11.

programs (e.g., EI and home visiting). For example, there are very few, if any, evidence based trainings available for providers. There are insufficient supplemental curricula available for providers to implement in a child care setting or home visiting program. Finally, it is often difficult for parents to identify their child as overweight or obese and broach the topic with an early care and education provider or physician.[46]

Child care providers and government agencies charged with supporting child care and preschools have noted that obesity-focused changes (especially changes in food and beverage offerings) are sometimes met with opposition from parents. For example, when centers remove fruit juice from menus and replace it with water, some parents see this as a cost-cutting measure rather than an effort to improve child nutrition. Early care and education providers may need support and guidance to educate families about the benefits of the changes they are making so that they are more acceptable to families.

The following recommendations are presented to help support early care and education providers in their efforts to prevent obesity:

Recommendations (Policy, Training, and Information)

POLICY:

1. DCFS should amend Rule 407[47] to include the recommendations from the Systems Integration and Alignment Committee, Health Subcommittee that were previously submitted, but not accepted, including:
    a. Programs should avoid serving concentrated sweets, such as candy, cupcakes, donuts, cookies, and other sugary foods.
    b. Children ages 12 months or older should participate in 60 minutes of age-appropriate moderate to vigorous physical activity per day. For children ages three (36 months) and older, at least 30 of the 60 minutes shall be structured and guided moderate to vigorous physical activity; the remainder of the physical activity may be concurrent with other active play, learning, and movement activities.
        i. Structured and guided physical activity shall be facilitated by teachers and/or child care providers and shall promote basic movement, creative movement, motor skills development, and general coordination.
        ii. Children attending a program less than six hours shall be scheduled to participate in a proportionate amount of such activities.
    c. Children attending a program less than six hours shall be scheduled to participate in at least one occasion of age-appropriate outdoor time.
    d. When screen time media is used, whether interactive or passive, it should be free of food and beverage advertising and brand placement.

[46] Rhee, Kyung E. et al. "Parent Readiness to Change Differs for Overweight Child Dietary and Physical Activity Behaviors." *Journal of the Academy of Nutrition and Dietetics* 114.10 (2014): 1601-1610.
[47] Ill. Adm. Code ch. 89, §407. Licensing Standards for Day Care Centers. 22 September 2014.

2. DCFS should update Rule 406[48] to align with the nutrition, physical activity, and screen time standards in Rule 407.[49]

TRAINING:

1. ISBE and IDHS should ensure that a training is created and available for early care and education providers on obesity prevention. This training should align with new requirements in Rule 407.

2. ISBE and IDHS should ensure that a training is created and available to early care and education providers on how to talk with families and parents about obesity and changes in child care menus, curriculum, and environments.

3. ISBE and IDHS should ensure that a training is created and available for families and parents through early childhood programs on obesity prevention in early childhood including importance of regular physical activity, nutrition education, cooking, etc.

4. ISBE and IDHS should ensure that a training is created and available for children enrolled in early childhood programs to expose them to the importance of regular physical activity, nutrition education, cooking, etc.

INFORMATION:

1. OECD, in partnership with IDPH, should ensure the creation and availability of public education (i.e., through a media campaign, published fact sheets, newsletter content) to raise awareness about the early origins of childhood obesity, the short- and long-term effects of obesity on children ages zero to eight, and the role that early care and education providers and settings can (and should) play in obesity prevention. Such materials should also focus on ending stigma associated with childhood obesity to encourage more productive conversations around the issue between early care and education providers and families of children in their care.

Existing Resources

1. The *We Choose Health* Initiative from IDPH is currently offering the Nutrition and Physical Activity Self Assessment for Child Care training through Gateways to Opportunity:
   http://www.ilgateways.com/en/

2. Illinois Action for Children provides professional development for child care providers in Cook County:

[48] Ill. Adm. Code ch. 89, §406. Licensing Standards for Day Care Homes. 13 December 2013.
[49] Ill. Adm. Code ch. 89, §407. Licensing Standards for Day Care Centers. 22 September 2014.

http://www.actforchildren.org/site/PageServer?pagename=Provider_ProfessionalDevelopment

3. DCFS Rule 407 provides best practice recommendations based on the current literature for physical activity, nutrition, and screen time: http://www.state.il.us/dcfs/docs/407.pdf

4. IDHS Child Care resources: http://www.dhs.state.il.us/page.aspx?item=29720

5. ISBE Nutrition and Wellness: http://www.isbe.net/nutrition/

6. USDA Child and Adult Care Food Program: http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program

7. Nutrition and Physical Activity Assessment for Child Care (NAP SACC) is a research-tested intervention designed to enhance nutrition and physical activity practices in early care and education programs by improving the nutritional quality of food served; amount and quality of physical activity; provider-child interactions around food and physical activity; educational opportunities for children, parents, and providers; and program policies related to nutrition and physical activity: http://gonapsacc.org/

8. *Let's Move!* Child Care recommendations: http://www.healthykidshealthyfuture.org/welcome.html

9. Illinois State Breastfeeding Task Force: http://www.illinoisbreastfeeding.org/

10. Obesity prevention resoures offered by NAEYC: http://www.naeyc.org/childhood_obesity_resources

11. The Women, Infants, and Children (WIC) program through IDHS provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk: http://www.dhs.state.il.us/page.aspx?item=30513

12. CDC Overweight and Obesity: http://www.cdc.gov/obesity/stateprograms/

13. CATCH Early Childhood program encourages healthy eating for children ages three to five: http://catchusa.org/cec.htm

14. Sesame Workshop *Healthy Habits for Life* program: http://www.sesameworkshop.org/what-we-do/our-initiatives/healthy-habits-for-life/

15. Consortium to Lower Obesity in Chicago Children (CLOCC)'s *5-4-3-2-1 Go!* healthy lifestyle message: http://www.clocc.net/partners/54321Go/index.html

16. *Kids Eat Right* from the Academy of Nutrition and Dietetics: http://www.eatright.org/kids/

17. AAP Institute for Healthy Childhood Weight: http://ihcw.aap.org

18. AAP Healthy Active Living for Families (HALF) project for providers: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/HALF-Implementation-Guide/Pages/HALF-Implementation-Guide.aspx

19. AAP Healthy Active Living for Families (HALF) project for parents: http://www.healthychildren.org/english/healthy-living/growing-healthy/Pages/default.aspx

20. USDA MyPlate: http://www.choosemyplate.gov/

21. Resources for child care providers and families through Child Care Aware: http://www.childcareaware.org/

22. U. S. Department of Health & Human Services Office of Child Care: http://www.acf.hhs.gov/programs/occ

23. U.S Department of Health & Human Services Office of Head Start: http://www.acf.hhs.gov/programs/ohs

24. U.S. Department of Health & Human Services Head Start *I Am Moving, I Am Learning* Program: https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/healthy-active-living/imil

SECTION FOUR:

Recommendations for Oral Health

Recommendations for Oral Health

Introduction to Issue

Establishing the foundation for long-term good oral health begins in the early childhood years. The health of a child's mouth can affect growth and development, the ability to eat nourishing food, the ability to learn in school, as well as self-esteem, behavior, and social interactions.[50] Practicing good oral hygiene begins at birth and is as important for a six-month-old child with one tooth as it is for a six-year-old with many teeth.[51]

Early childhood caries (the bacteria that causes tooth decay) is a common, infectious and transmissible chronic disease that disproportionally affects children from low-income and minority communities. By age five, about 60% of U.S. children will have had caries at some point, including the 40% of children who have it when they enter kindergarten.[52] Early prevention of early childhood caries is a cost-effective way for maintaining good oral health. However, the longer early childhood caries goes untreated, the more difficult and expensive it is to treat. Not only can decay and early loss of "baby teeth" affect speech and language development and comfort in eating solid foods, but it can also compromise the healthy growth of permanent teeth in later childhood. Furthermore, children with cavities in their "baby teeth" are three times more likely to develop cavities in their permanent teeth.[53]

Opportunities for promoting good oral health and mediating risk factors associated with early childhood caries can be leveraged within the early childhood system, especially since young children are spending an increasing amount of time in child care. Early care and education professionals play a significant role in the lives of young children. One of the most important roles that caregivers/teachers play is to model healthy behaviors and provide an environment that incorporates healthy practices into everyday activities.[54] These healthy practices can lead to skills that will promote good oral health and overall health in childhood and in adult life.

Although current quality improvement efforts in the state recognize the importance of embedding comprehensive services in early childhood programs, the early childhood provider's role in promoting good oral health is rarely prioritized. A study conducted by scholars at the University of Illinois at Urbana-Champagne, the University of Illinois at Chicago, and Duke University found that states appear to cover nutrition standards

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[50] "September 2012: School Readiness." *Brush Up on Oral Health* (Sept. 2012). The National Center on Health. <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/oral-health/PDFs/brushup-news-201209.pdf>.

[51] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association, 2011.

[52] *The State of Little Teeth Report: An Examination of the Epidemic of Tooth Decay Among our Youngest Children*. American Academy of Pediatric Dentistry, 2014.

[53] "Pregnancy and Early Childhood." *The State of Dental Health*. Children's Dental Health Project. <https://www.cdhp.org/state-of-dental-health/pregnancy-early-childhood>.

[54] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association, 2011.

better than oral health in their child care regulations, but that coverage of both nutrition and oral health areas was inadequate for prevention.[55]

Recent changes at the state policy level, however, position Illinois as a national leader of efforts to intervene on oral health in early childhood. In collaboration with the Health Subcommittee of the ELC's Systems Integration and Alignment Committee, DCFS and the Illinois Joint Commission on Administrative Rules published changes to Administrative Code Title 89, Chapter III, Subchapter E, Part 407: Licensing Standards for Day Care Centers in reference to increased oral health standards. While this policy change is a major accomplishment, not all of the recommendations were accepted and more work is needed to promote the successful implementation of this rule change in licensed childcare, to extend such improvements to licensed family childcare homes and licensed exempt providers, and to support other early childhood programs.

A study[56] conducted by the University of North Carolina at Chapel Hill found that HS teachers who received any formal oral health training were more likely to:

a. Provide classroom education about oral health.
b. Use fluoridated toothpaste in the classroom.
c. Help children brush their teeth in the classroom.
d. Advise parents on brushing their child's teeth.
e. Talk to parents about food choices that promote oral health.

The following recommendations will lead to a wider recognition and support for promoting oral health practices and education in early childhood settings:

Recommendations (Policy, Training, and Information)

POLICY:

1. DCFS should amend Rule 407[57] to include the recommendations from the Systems Integration and Alignment Committee, Health Subcommittee that were previously submitted, but not accepted, including:
   a. Require early care and education programs to encourage parents to establish a dental home for their child within six months after the first tooth erupts or by one year of age, whichever is earlier.[58]
   b. Starting at birth, early care and education staff should clean an infant's gums using water and a soft infant toothbrush or cloth preferably after meals.[59]

[55] Kim, Juhee et al. "Are State Child Care Regulations Meeting National Oral Health and Nutritional Standards?" *Pediatric Dentistry* 34.4 (2012):317-324.
[56] Kranz, Ashely M. et al. "Oral Health Activities of Early Head Start and Migrant and Seasonal Head Start Programs." *Journal of Health Care for the Poor and Underserved* 23.3 (2012): 1205–1221.
[57] Ill. Adm. Code ch. 89, §407. Licensing Standards for Day Care Centers. 22 September 2014.
[58] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association, 2011.

c. Require that all children with teeth should brush or have their teeth brushed at least once during the hours the child is in care if care is provided for five or more hours per day, preferably after a meal or a snack.[60] The staff should either brush the child's teeth or supervise as the child brushes his/her own teeth[61] and brushing should be supervised until the child can reliably rinse and spit out excess toothpaste (usually at six years of age).[62] The caregiver/teacher should teach the child the correct method of tooth brushing when the child is capable of doing this activity.[63]
d. Extend the current standard in Rule 407, Section 407.240 ("Evening, Night, Weekend, and Holiday Care") to all licensed child care centers, regardless of center business hours and days of operation: Each child shall have an individual toothbrush furnished either by the center or the child's parents.
e. Require that programs should not allow the sharing of a toothbrush with a child due to the risk of promoting early colonization of the infant oral cavity with Streptococcus mutans, bacteria that causes early childhood caries.[64]
f. Require that staff use a "smear" of toothpaste to brush the teeth of a child less than two years of age. For the two to five year old, staff should dispense a "pea-size" amount of toothpaste.[65]
g. Since all public water systems in Illinois are optimally fluoridated, children should drink water from the tap in order to reduce the risk of dental caries and tooth decay.[66, 67]

2. DCFS should update Rule 406[68] to align with the oral health and hygiene standards in Rule 407.[69]

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[59] *Policy on Oral Health in Child Care Centers*. American Academy of Pediatric Dentistry, 2011. <http://www.aapd.org/media/Policies_Guidelines/P_OHCCareCenters.pdf>.

[60] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association, 2011.

[61] Ibid.

[62] *A Pediatric Guide to Children's Oral Health: Flip Chart.* American Academy of Pediatrics, 2010. <http://www2.aap.org/oralhealth/docs/OralHealthFCpagesF2_2_1.pdf>.

[63] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association, 2011.

[64] Ibid.

[65] Adapted from *Parent Resources: Frequently Asked Questions.* American Academy of Pediatric Denistry, 2015. <http://www.aapd.org/resources/frequently_asked_questions/>.

[66] *Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States.* Morbidity and Mortality Weekly Report. 22 August 2001. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm>.

[67] According to the 2013 Delta Dental Children's Oral Health Survey, nearly 60 percent of caregivers say they are more likely to give children bottled water than tap water, potentially depriving kids of fluoride that is critical to good oral health. "Don't Bottle Up the Oral Health Benefits of Fluoridated Water." *Delta Dental News Room News Release* (April 2013). Delta Dental Plans Association. <http://www.deltadental.com/Public/NewsMedia/NewsReleaseDontBottleWater201304.jsp>.

[68] Ill. Adm. Code ch. 89, §406. Licensing Standards for Day Care Homes. 13 December 2013.

3. IDHS and ISBE should develop an incentive or funding requirement for programs to demonstrate a collaborative relationship(s) with local dental or primary care provider (e.g., an MOU)

4. Provide financial incentives for dentists, dental specialists, and dental hygienists to practice in medically underserved areas and serve Medicaid clients:
   a. The Illinois General Assembly should allocate sufficient funding to effectively implement Public Act 096-0757 which states that HFS shall establish an educational loan repayment assistance program for dentists, dental specialists, and dental hygienists who practice in designated shortage areas in Illinois and serve mostly Medicaid and CHIP clients
   b. Illinois dental colleges should provide financial incentives and scholarships to dental students committed to serving pregnant women and young children in linguistically isolated and medically underserved areas

TRAINING:

1. IDHS and ISBE should ensure that all early care and education program staff, but particularly staff that have direct contact with parents and caregivers, have knowledge of:
   a. the oral health risk factors for pregnant women and children ages zero to five
   b. best practices around nutrition, water consumption and brushing requirements as outlined by CFOC and the American Academy of Pediatric Dentists[70]
   c. the importance of establishing a dental home by age one and understand how to help families access a dental home

INFORMATION:

1. State agencies should promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice to all early care and education providers.

2. HFS, IDHS, and ISBE should partner with INCCRRA to promote regular (e.g., quarterly) dissemination to early care and education staff of an up-to-date health provider list that includes 1) pediatric dentists and 2) primary care physicians that have been trained through *Bright Smiles from Birth*.[71]

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[69] Ill. Adm. Code ch. 89, §407. Licensing Standards for Day Care Centers. 22 September 2014.

[70] American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association, 2011.

[71] *Bright Smiles from Birth* is an oral health education program offered through ICAAP for primary care providers that provides education on the prevention of early childhood caries and integrating oral health into well child visits.

Recommendations for Oral Health

Existing Resources

1. DentaQuest of Illinois, the All Kids Dental Program administrator, details what dental services are covered and can help staff/families find a dentist, as well as answer questions about dental care:
   http://www.dentaquest.com/ or 1-888-286-2447

2. The HS Oral Health Curricula Guide provides information about oral health-related curricula appropriate for use in EHS and HS programs:
   http://www.mchoralhealth.org/HeadStart/curricula/index.html

3. DCFS Rule 407 provides best practice recommendations based on the current literature for oral health and hygiene:
   http://www.state.il.us/dcfs/docs/407.pdf

4. Protecting All Children's Teeth (PACT) is a training program that aims to educate pediatricians, pediatricians in training, and others interested in infant, child, and adolescent health about the important role oral health plays in the overall health of patients. Downloadable presentations are available for use in trainings or educational settings:
   http://www2.aap.org/ORALHEALTH/pact/index-materials.cfm

5. Tips for good oral health during pregnancy:
   http://www.mchoralhealth.org/PDFs/OralHealthPregnancyHandout.pdf

6. Oral Health and motivational interviewing with parents:
   http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/center/oral-health/PDFs/discussing-oral-health-parents-children-dental-cavities.pdf

7. Talking with Children About Dental Visits:
   http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/center/oral-health/PDFs/brushup-news-201403.pdf

8. Oral Hygiene App for Children is a free, animated app created by United Concordia to help children ages four to 11 develop healthy brushing, flossing, and rinsing habits:
   https://www.unitedconcordia.com/dental-insurance/member/chomper-chums/

9. The National Maternal and Child Oral Health Resource Center (OHRC) has developed a publication, *Promoting Oral Health In Young Children: A Resource Guide*, to help health professionals, program administrators, educators, researchers, policy makers, parents, and others prevent disease and promote oral health in young children:
   http://www.mchoralhealth.org/PDFs/ResGuideYoungChildren.pdf

10. American Academy of Pediatric Dentistry:
    a. Caries-Risk Assessment Form for 0–3 Olds: For Physicians and Other Non-Dental Health Care Providers: http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf
    b. Caries-Risk Assessment Form for 0–5 Year Olds: For Dental Providers: http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf

11. American Academy of Pediatrics, Oral Health Risk Assessment Tool and Guidance: http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf

12. American Dental Association, Caries Risk Assessment Form (age zero to six): http://www.ada.org/~/media/ADA/Member%20Center/FIles/topics_caries_under6.ashx

13. Association of State and Territorial Dental Directors, Best Practice Approach: Prevention and Control of Early Childhood Tooth Decay: http://www.astdd.org/docs/BPAEarlyChildhood.pdf

14. Indian Health Service Early Childhood Caries Collaborative: http://www.ihs.gov/doh/index.cfm?fuseaction=ecc.display

15. National Institute for Children's Healthcare Quality, Early Childhood Caries Collaborative, Chronic Disease Management of Early Childhood Caries: http://www.nichq.org/childrens-health/early-childhood-caries-collaborative

SECTION FIVE:

Recommendations for Parental Depression

Recommendations for Parental Depression

Introduction to Issue

Parents are at highest risk for depression in the first year after the birth of a child, with younger parents and those with a history of depression at highest risk[72]. Although fathers are also at increased risk for depression in the first year of a child's life, women are more likely to have depression than men. Depressed parents can struggle to provide positive nurturing to their children and form strong, healthy attachments, leaving children most vulnerable to the impacts of parental depression during infancy. Such impacts include poor health outcomes and harm to emotional, cognitive, and behavioral development[73]. In addition, maternal depression during pregnancy can result in adverse effects such as higher risk of preterm delivery, higher risk of obstetrical complications, and decreased rates of breastfeeding.

Parental depression can also impact the effectiveness of some early care and education programs, particularly those that aim to support new parents in developing positive, healthy relationships with their babies, such as home visiting[74].

Fortunately, depression is highly treatable with antidepressant medications and traditional talk therapies. Some treatments have also been shown to reduce the risks to children of parental depression, including Clinician-Based Cognitive Psychoeducational Intervention for Families, Cognitive Behavioral Family Intervention (CBFI), and Parent-Child Interaction Therapy (PCIT) [75]. A further example is In-Home Cognitive Behavioral Therapy (CBT), which is a researched-based program that delivers CBT to mothers enrolled in home visiting programs. Unfortunately, many parents do not get the help they need due to stigma, access barriers to treatments, and underidentification.

Because of the close relationships that many early care and education programs have with families, these programs are uniquely positioned to identify families that are struggling with parental depression and support them in getting help. In addition, early care and education programs can mediate some of the negative impacts of parental depression, thus building resiliency and supporting the health and development of at-risk children[76]. Currently, very few early care and education programs systematically screen for depression; and very little training and support is provided to these programs to assist them in recognizing depression, talking with parents about depression, and connecting parents to appropriate treatment.

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[72] Davé, Shreya et al. "Incidence of Maternal and Paternal Depression in Primary Care: A Cohort Study Using a Primary Care Database." *Arch Pediatr Adolesc Med* 164.11 *(*2010): 1038-1044.

[73] *Parental Depression: Indicators on Children and Youth.* Child Trends Data Bank, Aug 2014. <http://www.childtrends.org/wp-content/uploads/2014/08/54_Parental_Depression1.pdf>.

[74] "Maternal Depression." *Moving Beyond Depression*. Every Child Succeeds. <http://www.movingbeyonddepression.org/maternal-depression>.

[75] *Parental Depression: Indicators on Children and Youth.* Child Trends Data Bank, Aug 2014. <http://www.childtrends.org/wp-content/uploads/2014/08/54_Parental_Depression1.pdf>.

[76] Giles, Lynne C. et al. "Maternal Depressive Symptoms and Child Care During Toddlerhood Relate to Child Behavior at Age 5 Years." *Pediatrics* 128.1 (2011): e78-e84.

Recommendations for Parental Depression

CFOC has presented recommendations for public comment that early care and education programs have a written plan and training for handling urgent medical care or threatening incidents, including mental health emergencies[77]. However, more can be done to address parental depression. In order to ensure that Illinois' early childhood systems are appropriately prepared to serve families impacted by parental depression, early care and education providers will need additional training, support, and information. In addition, policies should be developed to support these additional needs.

The following recommendations outline steps that can be taken to achieve the goal of supporting families impacted by parental depression. Because detection and identification of parental depression is particularly sensitive to cultural and language differences, all training, screening and assessment tools, and materials should acknowledge and be sensitive to such differences.

Recommendations (Policy, Training, Support, and Information)

POLICY:

1. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should require that persons working with infants and toddlers in early childhood systems receive training on the effects of parental depression.

2. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should require that all early care and education programs that already screen for maternal/paternal depression have protocols in place for immediate referral should there be severe indications of depression or suicide ideation.

3. The ELC and ICMHP should examine whether it is appropriate and feasible to conduct maternal/paternal depression screenings in all early care and education programs who do not currently do so and incorporate screenings into programs as appropriate.

4. The ELC and ICMHP should identify or develop new models for delivering treatment for depression to parents that capitalize on the unique connections early care and education programs have with families while overcoming structural barriers to depression treatment. The feasibility of utilizing these models in Illinois should be evaluated and strategies to finance and implement them at scale should be developed.

[77] Department of Health and Human Services, Administration for Children and Families. "Caring For Our Children Basics; Comment Request." *Federal Register* 79.243. (18 Dec 2014): 75557-75564. <https://federalregister.gov/a/2014-29649>.

Recommendations for Parental Depression

TRAINING:

1. The ELC, ICMHP, ICAAP, Erikson Institute, the Ounce Institute, and other Illinois early childhood mental health and training experts should work together with INCCRRA to identify or develop training (if such a training does not currently exist) for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.

SUPPORT:

1. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should work with ICMHP to ensure that programs that provide early care and education services are aware of and know how to access mental health consultation and treatment providers in order to support both staff members and young children and their families.

2. HFS should disseminate a list of behavioral health services available through Medicaid, including instructions for accessing these services, to the state agencies for dissemination to all providers. This resource should be available to both staff and families.

3. The ELC and ICMHP should research the possibility of extending the services provided by the University of Illinois at Chicago Perinatal Consultation Line to early care and education providers (it is currently targeted toward medical providers). If services cannot be extended, they should consider establishing a "warm line" that can provide training resources, tools to help with screening and referral, and telephone consultation for providers.

INFORMATION:

1. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should disseminate information on maternal and paternal depression and the impact on child development to these providers.

Existing Resources

1. Mental Health Consultation models currently exist in some programs and are provided in some funding streams, such as EHS/HS; MIECHV; IDHS through Caregiver Connections; CFCs; etc.

Recommendations for Parental Depression

2. Training modules on perinatal maternal depression screening are available on the EDOPC website with links to other websites and resources: http://illinoisaap.org/e-learning/

3. The guidelines on perinatal depression screening from the AAPs' *Bright Futures* Initiative have been incorporated in the Medicaid Healthy Kids Handbook, which is be available to all providers: http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/Chapter200.aspx

4. Training on Special Interest topics that includes perinatal depression, is available for home visiting programs through the OECD's Strong Foundations Partnership. Training is administered through the Ounce Institute: https://www2.illinois.gov/gov/OECD/Pages/HomeVisiting.aspx

5. Illinois Public Act 095-0469, which mandates that hospitals and health providers invite mothers to have an optional perinatal depression screening at prenatal, postnatal, and well-baby visits, was passed and made effective in 2008. Currently, the rules have been reviewed by IDHS legal and are in review with executive staff: http://www.dhs.state.il.us/page.aspx?item=35251

6. Evanston Northwestern Hospital Perinatal Depression Program Consumer Crisis Hotline:
   1-866-ENH-MOMS (1-866-364-6667)

7. University of Illinois at Chicago Perinatal Consultation Line:
   1-800-573-6121, http://www.psych.uic.edu/clinical/HRSA

8. HFS resources website: http://www2.illinois.gov/hfs/MedicalCustomers/MaternalandChildHealthPromotion/Pages/Perintal.aspx

9. Postpartum Depression Alliance of Illinois: http://www.ppdil.org/

10. The Mothers and Babies Course (MB Course) is a CBT-based postpartum depression prevention intervention that integrates proven CBT methods for reducing depressive symptoms with methods aimed at increasing maternal self-efficacy. The Illinois MIECHV team is currently using this resource: http://medschool2.ucsf.edu/latino/pdf/mb_instructorsEN/M&B%20Entire%20Inst%20Manual%203-22-07/M&B%20InstrManual%203-22-07MaD.pdf

SECTION SIX:

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

Introduction to Issue: Lead Screening

Lead poisoning can be the cause of cognitive and other developmental delays as well as behavioral issues in early childhood as even low levels of lead poisoning are linked to hyperactivity, reduction in IQ, and behavioral issues in young children.[78] The CDC estimates that 535,000 children under age six have elevated blood lead levels.[79] Currently, the Lead Poisoning Prevention Act requires all physicians to perform lead assessments and tests in accordance with intervals listed in the IDPH Childhood Lead Risk Health Assessment Questionnaire.[80] However, the same act only requires early care and education providers to collect evidence of an initial lead poisoning test (for children living in high-risk zip codes) or risk screening (for children in low-risk zip codes) before enrollment and "in conjunction with required child health examinations."[81]

Child health examinations are required every two years in home-[82] and center-based[83] early care and education programs, and recommended but not required every two years for school-based programs.[84] The AAP states that blood lead concentrations generally peak in children at approximately two to three years of age.[85] The AAP[86] and the IDPH Childhood Lead Risk Assessment Questionnaire[87] both recommend that children receive screenings or blood lead tests at least as often as 12 and 24 months of age. HS programs in Illinois require lead screenings or tests at 12 and 24 months in accordance with state Medicaid EPSDT program schedules,[88] which are informed by AAP recommendations.[89] The Lead Poisoning Prevention Act should be amended to require all early care, education and intervention programs to provide evidence of lead poisoning screenings

[78] Advisory Committee on Childhood Lead Poisoning Prevention. *Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention*. Centers for Disease Control and Prevention, 2012.
[79] Wheeler, William, and Mary Jean Brown. "Blood Lead Levels in Children Aged 1-5 Years – United States, 1999-2010." *Morbidity and Mortality Weekly Report* 62.13 (5 April 2013): 245-248. Centers for Disease Control and Prevention.
[80] Lead Poisoning Prevention Act. P. A. 98-690. 410 ILCS 45 §6.2(a). 1 January 2015.
[81] Poisoning Prevention Act. P. A. 98-690. 410 ILCS 45 §7.1. 1 January 2015.
[82] Ill. Adm. Code ch. 89, §406.14(c)(1). Health, Medical Care and Safety. 13 November 2006.
[83] Ill. Adm. Code ch. 89, §407.310(a)(3). Health Requirements for Children. 1 August 2014.
[84] Ill. Adm. Code ch. 77, §655.140(e). Timetable for Examinations. 11 May 2009.
[85] American Academy of Pediatrics Committee on Environmental Health. "Lead Exposure in Children: Prevention, Detection, and Management." *Pediatrics* 116.4 (2005): 1036 -1046.
[86] American Academy of Pediatrics Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Workgroup. "2014 Recommendations for Pediatric Preventive Health Care." *Pediatrics* 133.3 (2014): 568–570.
[87] *Childhood Lead Risk Assessment Questionnaire*. Illinois Department of Public Health, Illinois Lead Program. <http://www.idph.state.il.us/envhealth/pdf/Lead_LRAQ_6_07.pdf>.
[88] Head Start Performance Standards, 45 CFR §1304.20(a)(1)(ii). Child health and developmental services. 8 January 2008.
[89] American Academy of Pediatrics Committee on Practice and Ambulatory Medicine, Bright Futures Periodicity Schedule Workgroup. "2014 Recommendations for Pediatric Preventive Health Care." *Pediatrics* 133.3 (2014): 568–570.

or tests based on the schedule indicated in the IDPH Childhood Lead Risk Assessment Questionnaire.[90]

Blood tests are required for high-risk children because the developmental and cognitive delays symptomatic of lead poisoning often go undetected until as late as kindergarten.[91] Because visible symptoms and effects are often not seen until months or even years after a child has been lead poisoned, children who test positive for lead poisoning should receive automatic eligibility for EI services. Currently, children with lead poisoning are not guaranteed EI services because lead poisoning is not listed as a condition resulting in high probability of developmental delay.[92] In order to receive EI services in Illinois, a child with lead poisoning must undergo a multidisciplinary evaluation and assessment which establishes that the child exhibits a developmental delay of 30% or greater;[93] or if the child doesn't exhibit a 30% delay, the child could be determined eligible only if according to "informed clinical opinion of qualified staff" the child is at risk of substantial developmental delay."[94]

Unfortunately, current practice captures only a small percentage of children with lead poisoning, many of whom will be negatively affected by developmental delays when reaching school age. Recently, a study of almost 50,000 students in the Chicago Public School District found that even low-level exposure to lead reduces standardized test performance and increased risk of school failure.[95] With automatic EI eligibility, families could access services across multiple domains that meet their goals, which could help ensure a lead-safe home, proactively address future cognitive delay, or receive related interventions that the family identifies as potentially helpful. Automatic access to EI services would maximize opportunities for children to overcome developmental delays before school performance declines.

Currently, local health departments conduct environmental lead risk assessments in homes of children, but only for those already identified with high blood lead levels[96]. Tools and training exist to enable home visitors in early care and intervention programs to conduct visual inspections for all the families they visit, allowing them to identify home-based hazards before children test positive for lead poisoning. Homes where hazards are detected could be referred to the existing programs at health departments for further follow up and inspection. Early detection could prevent prolonged exposure to lead and minimize the advancement of developmental delays as a result.

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[90] *Childhood Lead Risk Assessment Questionnaire.* Illinois Department of Public Health, Illinois Lead Program. <http://www.idph.state.il.us/envhealth/pdf/Lead_LRAQ_6_07.pdf>.

[91] Advisory Committee on Childhood Lead Poisoning Prevention. *Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention*. Centers for Disease Control and Prevention, 2012.

[92] Ill. Adm. Code ch. 89, §500, Appendix E. Medical Conditions Resulting in High Probability of Developmental Delay (not an exclusive list). 23 January 2008.

[93] Ill. Adm. Code ch. 89, §500.50(a)(1). Eligibility. 12 May 2014.

[94] Ibid.

[95] Advisory Committee on Childhood Lead Poisoning Prevention. *Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention*. Centers for Disease Control and Prevention, 2012.

[96] Lead Prevention Program. *Keeping Homes Healthy and Safe.* Illinois Department of Health, 2011. < http://www.idph.state.il.us/illinoislead/HealthyHomes.pdf>.

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

Recommendations (Policy, Training, and Information): Lead Screening

POLICY:

1. IDPH should amend the Lead Poisoning Prevention Act P.A. 94-879 §7(1) to require all early care, education and intervention programs to collect evidence of lead screenings or tests in accordance with the IDPH Childhood Lead Risk Assessment Questionnaire guidelines.

2. IDHS should explicitly list lead poisoning in 89 Illinois Administrative Code §500, Appendix E "Medical Conditions Resulting in High Probability of Developmental Delay" to guarantee children with lead poisoning automatic eligibility for EI services.

3. The ELC's Data, Research and Evaluation Committee should recommend that lead screenings be included in the Unified Early Childhood Data System to help track the administration of these screenings as a valuable outcome.

TRAINING:

1. Gateways to Opportunity should adapt the IDPH Lead Program's visual lead risk assessment training for early care, education and intervention providers who perform regular home visits in EI or home-based EHS programs.

INFORMATION:

1. IDPH should develop and distribute materials to all early care and education providers explaining the signs of lead presence in the home as well as early symptoms of lead exposure.

Existing Resources: Lead Screening

1. Department of Housing and Urban Development: Office of Lead Hazard Control and Healthy Homes: http://portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes

2. IDPH Illinois Lead Poisoning Prevention Program: http://www.idph.state.il.us/illinoislead/

3. National Center for Healthy Housing: National Healthy Homes Training Center and Network: http://www.nchh.org/portals/0/contents/hhtc_fact_sheet_may2014.pdf

4. Lead Safe Illinois: http://www.leadsafeillinois.org/

5. National Center for Healthy Housing 2013 Report: http://www.nchh.org/Policy/2013StateofHealthyHousing.aspx

6. Protect Your Family From Lead in Your Home: http://www2.epa.gov/sites/production/files/2013-09/documents/lead_in_your_home_brochure_land_color_508.pdf

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

Introduction to Issue: Vision Screening

In one's lifetime there are two particularly vulnerable periods for vision loss or blindness – early childhood and the elderly years. What sets early childhood apart is the critical timing in a child's development. The brain is actively wiring the visual system via stimulation and input received through the eyes. If a child's vision is blurred by near- or farsightedness he or she is not receiving full stimulation to develop light and dark contrast or clear, sharp acuity.

The most concerning disorder is amblyopia (poor vision or blindness due to lack of visual system development, or "lazy eye") and its primary risk factors, strabismus (improper eye alignment) and significant refractive error (near- or farsightedness),[97,98] are the most common visual disorders in preschool children.[99] Evidence suggests that the success of amblyopia treatment is influenced by a child's age, with children younger than seven years of age being more responsive to amblyopia treatment.[100] Early diagnosis of amblyopia is particularly important as there is strong evidence for best outcomes with treatment begun by age four and good results with treatment begun by age six.[101] A recent report concluded that early treatment of amblyopia results in improved visual outcomes.[102] In addition, optical correction of significant refractive error can influence a child's general development[103] and improve school readiness.[104,105] Healthy People 2020 specifically includes the goal of increasing vision screening rates in children aged five years and under, with a modest 44% target.[106] In addition, USPSTF has endorsed preschool vision screening for children three to five years of age,[107] and the AAP's *Bright Futures* Guidelines[108] recommend vision screening for all children to detect amblyopia or risk factors for the development of amblyopia.

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[97] Tarczy-Hornoch, K, et al. "Prevalence and Causes of Visual Impairment in Asian and non-Hispanic White Preschool Children: Multi-Ethnic Pediatric Eye Disease Study." *Ophthalmology* 120.6 (2013): 1220-1226.

[98] Tarczy-Hornoch, K,et al. "Risk Factors for Decreased Visual Acuity in Preschool Children: the Multi-Ethnic Pediatric Eye Disease and Baltimore Pediatric Eye Disease Studies." *Ophthalmology* 118.11 (2011): 2262-2273.

[99] US Preventive Services Task Force. "Vision Screening for Children 1 to 5 years of Age: US Preventive Services Task Force Recommendation Statement." *Pediatrics* 127.2 (2011): 340-346.

[100] Holmes, JM, et al. "Effect of Age on Response to Amblyopia Treatment in Children." *Arch Opthalmol* 129.11 (2011): 1451-1457.

[101] Ibid.

[102] US Preventive Services Task Force. "Vision Screening for Children 1 to 5 years of Age: US Preventive Services Task Force Recommendation Statement." *Pediatrics* 127.2 (2011): 340-346.

[103] Ibironke JO, et al. "Child Development and Refractive Errors in Preschool Children. *Optom Vis Sci* 88.2 (2011): 181-187.

[104] Roch-Levecq AC, et al. "Ametropia, Preschoolers' Cognitive Abilities, and Effects of Spectacle Correction." *Arch Ophthalmol* 126.2 (2008): 252-258.

[105] Atkinson J, et al. "Infant Vision Screening Predicts Failures on Motor and Cognitive Tests up to School Age." *Strabismus* 10.3 (2002): 187-198.

[106] *Healthy People 2020 Objective V-1*. US Department of Health and Human Services. <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=42>.

[107] US Preventive Services Task Force. "Vision Screening for Children 1 to 5 Years of Age: US Preventive Services Task Force Recommendation Statement." *Pediatrics* 127.2 (2011): 340-346.

[108] *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. American Academy of Pediatrics. <http://brightfutures.aap.org/pdfs/Guidelines_PDF/13-Rationale_and_Evidence.pdf>.

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

The Illinois Child Vision and Hearing Test Act (410 ILCS 205) currently mandates that all children aged three or older enrolled in any public or private preschool, HS program, or licensed day-care center must be provided an annual vision screening. As per the Illinois mandate, IDPH is responsible for training and certifying all vision and hearing screeners in the state. IDPH is also responsible for establishing the screening protocols and practices.

Since 2010 the Illinois Children's Vision Coalition (a broad-based collaboration of state agencies, early childhood providers, educators, non-profits and vision experts) has studied Illinois vision screening issues. A 2012 survey of two child care center directors per county revealed that 25% did not conduct vision screenings. This impacted over 5,600 children in their care. Multiplied out across the state this could represent over 55,000 children not being screened each year.

The Coalition's gap analysis and surveys confirmed the consensus that:

1. more vision screeners are needed to achieve the State mandate;
2. more trainings should be offered for those interested in becoming a screener;
3. trainings are designed for ages three through high school requiring those needing only preschool-aged screening skills to acquire expensive equipment for school-aged children and receive training that will not be used;
4. administrative codes should be written to allow usage of improved vision screening tools and protocols;
5. screeners need assessable support to keep skills sharp and to assure consistent referrals and follow-up for children;
6. screening and referral data should be incorporated into other health data systems capturing more than just aggregate numbers;
7. parents and early childhood providers need a greater understanding of vision development.

The Coalition's response to these gaps is to create a vision screening system that:

1. improves compliance for early childhood programs in meeting their state-mandated screening requirements;
2. adheres to best practices established by the National Center for Children's Vision and Eye Health;
3. allows flexibility to update to the most cost effective, scientifically proven screening protocols as information evolves;
4. assures geographically accessible training across the state;
5. provides a separate three-to-five-year-old only certification and recertification (Currently screeners must be certified age three through high school. School-age screening requires expensive equipment and extensive training time. This certification would remain intact for those serving that wider age range.);
6. provides a training curriculum with more age-specific information, reflects the current knowledge base of vision screening best practices; and eliminates unnecessary information not relevant to vision screening;
7. create an ongoing support system for screeners with information on screening protocols and vision health.

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

Budget cuts have challenged the Office of Hearing and Vision Screening at IDPH but outside resources are available to take the lead or assist with the demands for improvement. The Coalition is well aware of the constraints of staff and time faced by the Office and is prepared to undertake the re-writing of the vision screening curriculum specifically utilizing the assistance of Prevent Blindness Illinois and the Illinois College of Optometry. Additionally, Illinois has a well-established training and certification system through Gateways to Opportunity and channeled to the CCR&R system. Training quality and reliability is well proven.

At the present time, there is no scientific evidence to support the benefit or validity of vision screening children less than 36 months of age with instrument-based methods or tests of recognition visual acuity. If a parent or guardian requests a vision screen or if the provider is concerned for any reason, the child should be referred directly for evaluation by an eye care provider. Therefore, the following recommendations only address the three to five population.

Recommendations (Policy and Training): Vision Screening

POLICY:

1. IDPH should establish an additional certification and recertification option for technicians to conduct vision screenings for children ages three to five only.

2. IDPH should authorize early childhood training entities to conduct trainings that qualify for DPH certification and recertification vision screening option for children ages three to five.

3. IDPH should revise vision screening administrative codes (Vision Screening Section 685) to follow the screening protocols recommended and continually assessed by the National Center for Children's Vision and Eye Health.

4. IDPH should establish or authorize through another entity an Early Childhood Vision Screening Resource Center to provide ongoing skill supports and technical assistance for certified early childhood vision screeners.

5. The ELC's Data, Research and Evaluation Committee should recommend that mandated vision screenings be included in the Unified Early Childhood Data System to help track the administration of screening as a valuable outcome.

TRAINING:

1. IDHS, ISBE, and DPH, along with INCCRRA should provide training for early childhood care providers and educators on vision and eye health, signs of vision problems in children, and state-wide guidelines for finding assistance in addressing the vision health of children ages three to five.

2. IDPH should develop training for early care and education providers on the state vision screening mandates and disseminate this training through IDHS and ISBE, along with INCCRRA.

Existing Resources: Vision Screening

1. American Academy of Ophthalmology: http://www.geteyesmart.org/eyesmart/

2. American Academy of Pediatrics, *Bright Futures* is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community and is used in pediatric health practice: http://brightfutures.aap.org/

3. American Association for Pediatric Ophthalmology and Strabismus: http://aapos.org/

4. American Optometric Association: http://www.aoa.org/

5. National Center for Children's Vision and Eye Health supports the development of a public health infrastructure to promote and ensure a comprehensive, multi-tiered continuum of eye health and vision care for young children: http://nationalcenter.preventblindness.org

6. Prevent Blindness is the nation's leading volunteer eye health and safety organization dedicated to fighting blindness and saving sight: www.preventblindness.org

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

Introduction to Issue: Hearing Screening

Hearing loss is the most prevalent disorder present at birth. In addition, children with high risk factors are at an increased risk for progressive hearing loss[109] and children without high risk factors can be at risk for progressive, delayed onset, fluctuating, or acquired hearing loss in the critical language acquisition time period from zero to five years of age. It is estimated that nine to ten per 1000 children will have identifiable permanent hearing loss in one or both ears by school age. Prompt diagnosis and quality early intervention help children with hearing loss not only overcome language development delays and poor literacy outcomes, but also enhance social and emotional skills that can be stunted by missed or late diagnosis. Early diagnosis and intervention is associated with language development at or near the typical rate of development[110]. Age-appropriate language development and literacy outcomes require early and ongoing attention to skill development in the first years of life. For the effects of hearing loss on skill development and socialization to be remediated, it first is necessary for childhood hearing loss to be identified as early as possible. Children who are identified later or have been missed for follow-up can have issues that lead to significant delays in speech and language acquisition, as well as subsequent educational, cognitive, and social consequences. Evidence suggests that for nine-year-olds with educationally significant hearing loss, up to 50% will have passed newborn hearing screening, thus making continued monitoring of the auditory status of infants, toddlers, and young children critical[111].

It is known that children who do not receive early intervention can cost schools an additional $420,000 per child in special education services and are faced with overall lifetime costs of $1 million in special education, lost wages, and health complications[112].

Early screening methods are safe, effective ways to quickly and reliably identify hearing loss. Currently, Illinois newborns are screened for hearing loss before being discharged from the hospital via guidelines for the Universal Newborn Hearing Screening Law/Act[113]. No current regulations exist to mandate any screening between discharge from the hospital at birth and entering school. Therefore, children who are subject to progressive, delayed onset, acquired, or fluctuating hearing loss will not be identified and will not receive appropriate interventions during the early years of life, the critical language acquisition time. The Child Vision and Hearing Test Act (PA 81-174) states that vision and hearing services shall be administered to all children as early as possible, but no later than their first year in any public or private education program, licensed day

[109] Joint Committee on Infant Hearing. "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs." *Pediatrics* 106.4 (2000):798-817.

[110] Yoshinaga-Itano, C., Sedey, A. L., Coulter, D. K., & Mehl, A. L. "Language of Early-and Later-identified Children with Hearing Loss." *Pediatrics* 102.5 (1998): 1161-1171.

[111] *Clinical Practice Guidelines: Childhood Hearing Screening.* American Academy of Audiology, Sept 2011. <http://audiology-web.s3.amazonaws.com/migrated/ChildhoodScreeningGuidelines.pdf_5399751c9ec216.42663963.pdf>.

[112] Mohr, P. E., et al. "The Societal Costs of Severe to Profound Hearing Loss in the United States." *International Journal of Technology Assessment in Health Care* 16.04 (2000): 1120-1135.

[113] Patel, H., and M. Feldman "Universal Newborn Hearing Screening." *Pediatric Child Health* 16.5 (2011): 301-305.

care center or residential facility for handicapped children; and periodically thereafter, to identify those children with vision or hearing impairments or both so that such conditions can be managed or treated.

IDPH Administrative Rule 675 concerning hearing screening does not require a hearing screening program for children less than three years of age. The administrative code does not include a process for certifying technicians to screen zero to three year olds and screening using otoacoustic emission (OAE) technology is not addressed in administrative code. OAE screening is a safe reliable method and is effective if performed by trained professionals. Currently, Illinois does not utilize resources and does not have a sufficient training method for EHS providers with this zero to three population. However, screening is a requirement by HS and other home visiting programs and is also a best practice within IDEA as part of an IEP evaluation process. In Illinois, the certification provided by IDPH for Audiometric and Vision Screening Technicians allows technicians to perform mandated screenings per the IDPH Rules and Regulations on children ages three and older (through high school graduation). Lack of funding to provide training and certification for these hearing screenings results in a delay of intervention and children going undiagnosed.

Recommendations (Policy, Training, and Information): Hearing Screening

POLICY:

1. IDPH should partner with the Illinois EHDI program and its ECHO Initiative to develop a standardized hearing screening protocol for early care and education programs serving children ages zero to three years.

2. IDPH should establish an additional certification and recertification option for technicians to conduct hearing screenings utilizing OAE technology for children ages zero to three years.

3. IDPH should authorize early childhood training entities to conduct trainings that qualify for IDPH certification and recertification hearing screening option for children ages zero to three years as well as three to five years.

4. IDPH should establish or authorize through another entity an Early Childhood Hearing Screening Resource Center to provide ongoing skill supports and technical assistance for certified early childhood hearing screeners while partnering with EHDI and ECHO.

TRAINING:

1. IDPH should partner with EHDI and the ECHO Initiative to develop and provide standardized training, in addition to their current training, to allow for certification and recertification of hearing screeners to screen children zero to three years old.

Recommendations for Physical Health Screening: Lead, Vision, and Hearing

2. IDHS, ISBE, and IDPH (with INCCRRA) should provide training for early care and education providers on auditory health, signs of hearing problems in children, and statewide guidelines for finding assistance in addressing the auditory health of children zero to five years old.

3. IDPH should develop a standardized training and curricula, in addition to the current preschool resources through school-age training, to allow for certification and recertification of vision and hearing screeners for all early care and education programs zero to three and three to five years.

INFORMATION:

1. IDPH should disseminate information on the state hearing screening mandates to IDHS, ISBE, DCFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services.

Existing Resources: Hearing Screening

1. American Academy of Audiology: http://www.audiology.org

2. American Speech-Language-Hearing Association: http://www.asha.org

3. Early Childhood Hearing Screening & Follow-up: http://www.kidshearing.org

4. National Center for Hearing Assessment and Management (NCHAM): http://www.infanthearing.org

5. CDC, Parent's Guide to Hearing Loss: http://www.cdc.gov/ncbddd/hearingloss/index.html

6. Joint Commission on Infant Hearing 2007: http://www.jcih.org/posstatemts.htm

7. Joint Committee on Administrative Rules Administrative Code, Title 77 Public Health Subchapter J: Vision and Hearing, part 675 Hearing Screening: http://www.ilga.gov/commission/jcar/admincode/077/07700675sections.html

8. The HS Program Performance Standards (45 CFS 1304.20(b)): http://eclkc.ohs.acf.hhs.gov/hslc/standards/hspps/1304/1304.20%20child%20health%20and%20developmental%20services..htm

9. 410 ILCS 205/ Child Vision and Hearing Test Act: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1538&ChapterID=35

SECTION SEVEN:

Recommendations for SIDS, SBS, and Product Safety

Recommendations for SIDS, SBS, and Product Safety

Introduction to Issue

The subjects covered by this recommendation are targeted towards protecting healthy infants, toddlers and young children. While SIDS may not be completely preventable, we can significantly reduce the likelihood of a sleep related infant death by following well established standards and practices endorsed by the AAP and many other health organizations. The same is true with regard to SBS (sometimes called Traumatic Head Injury) and product safety.

Due to the consensus of understanding that these are fundamentally preventable deaths, the Illinois General Assembly, DCFS, the CCR&Rs and others have worked together to set some excellent systems in place to protect the young children of Illinois. However, there is more that can be done.

The seriousness of these issues is not simply targeted at developing healthy, happy, well-developed children but at actually saving the lives of children. In Illinois, SIDS is the leading cause of post-neonatal death. [114] While Illinois does not keep records regarding the exact number of deaths in child care, national research finds that 20% of the infants that die from sleep related deaths die while in child care.[115] Based on the number of infants in child care, that number should be closer to 8%. For SBS , national statistics report that 17% of shaken babies are injured by a female child care provider.[116] Yet our SBS training does not include coping strategies for infant providers who have high levels of stress due to irritable or difficult babies in their care.

Currently, DCFS has a mandate to review deaths of minors under the age of 18 that are currently wards of the state or have open cases (within 1 year) with the agency. Child care is the only excluded group from DCFS responsibility that is not reviewed by mandate. Since the purpose of the CDRTs is to review these deaths, it makes sense to include child care that is licensed and overseen by DCFS in this mandate.

The Child Care Act[117] requires licensed child care providers to have SIDS, Safe Sleep and SUID training once every three years. Providers are required to have training on SBS only once.

We have vastly improved in the area of product safety due to the CPSC's increased oversight of children's and infant's products. We have a procedure in place to inspect product safety in licensed child care; however, that procedure is not very well defined nor is it consistent in its review. Child care providers sign a document saying that they have checked their site for recalled products and then DCFS Licensing Representatives review the paper. Some inspectors do not mention recalled products at all, while others

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[114] *Leading Causes of Infant Death, Illinois, 2010.* Illinois Department of Public Health. <http://www.idph.state.il.us/health/bdmd/infantmortalitycauses_10.htm>.

[115] Moon, Rachel Y., Trisha Calabrese and Laura Aird. "Reducing the Risk of Sudden Infant Death Syndrome in Child Care and Changing Provider Practices: Lessons Learned from a Demonstration Project." *Pediatrics* 122.4 (2008): 788-798.

[116] *Facts & Stats*. Shaken Baby Prevention. <http://www.sbsprevention.com/facts_stats.htm>.

[117] The Child Care Act of 1969. P.A. 97-83. 225 ILCS 10 §7(a)(16). 13 August 2009.

look at every product. An example of the inconsistencies in reviews is the requirement that child care providers no longer use drop-sided cribs. The only proof required is the certificate from the manufacturer that they meet current ASTM guidelines.

The following recommendations are offered in support of continuing the excellent work that has been started.

Recommendations (Policy, Training, and Support)

POLICY:

1. SIDS, SBS & Product Safety: DCFS should include deaths of a minor child in a licensed or licensed-exempt child care center or home in the CDRT system.

2. Product Safety: DCFS should link directly with the Consumer Product Safety Commission's recall list so that it is always complete and accurate and DCFS should require licensed providers to sign up for alerts from the CPSC.

3. Product Safety: DCFS should be required to have a consistent policy for reviewing equipment safety at every site visit including verification of supporting documentation that products meet current federal manufacturing guidelines set forth by the ASTM.

4. Product Safety: DCFS should amend Child Care Licensing Rule 407 and 406 to include language in licensing to require that products be used as the manufacturer intended in the instructions.

TRAINING:

1. SIDS: INCRRA should be required to update SIDS online training at least once every three years or whenever a significant change in the AAP recommendations is announced.[118]

2. SBS: INCRRA should be required to update the online SBS class to include suggestions for handling provider stress and help on recognizing the signs and symptoms of TBI and to update that training whenever a significant change in the reasearch is announced by the AAP.

3. SIDS & SBS: PAT and other home visiting programs should require training for home visitors rather than recommend.

[118] "AAP Expands Guidelines for Infant Sleep Safety and SIDS Risk Reduction." *healthychildren.org*. American Academy of Pediatrics, 18 Oct 2011. <http://www.healthychildren.org/English/news/pages/AAP-Expands-Guidelines-for-Infant-Sleep-Safety-and-SIDS-Risk-Reduction.aspx>.

Recommendations for SIDS, SBS, and Product Safety

SUPPORT:

1. DCFS should expand the network of licensing representatives so that it includes Product Safety Inspectors.

Existing Resources

1. Sudden Infant Death Syndrome:
    a. IDPH SIDS and Infant Mortality Program: http://www.idph.state.il.us/sids/index.htm
    b. *Safe to Sleep* Campaign, led by the Eunice Kennedy Shriver National Institute of Child Health and Human Development: http://www.nichd.nih.gov/sts/Pages/default.aspx
    c. SIDS Center: http://www.mchlibrary.org/suid-sids/index.html
    d. Gateways to Opportunity online training, "Sudden Infant Death Syndrome and the Child care Profession": http://ilearning.inccrra.org/providers/illinois-dcfs-trainings.html
    e. Healthy Child care America online training: http://www.healthychildcare.org/sids.html

2. Shaken Baby Syndrome:
    a. Gateways for Opportunity online training, "A Preventable Tragedy, Shaken Baby Syndrome": http://ilearning.inccrra.org/providers/illinois-dcfs-trainings.html
    b. The National Center on Shaken Baby Syndrome (NCSBS): http://www.dontshake.org
    c. NCSBS's *Period of Purple Crying* online training: http://www.dontshake.org/lms/lms_information/lms_course.php
    d. National Institute of Neurological Disorders: http://www.ninds.nih.gov/disorders/shakenbaby/shakenbaby.htm
    e. Shaken Baby Prevention: http://www.sbsprevention.com/
    f. Prevent Child Abuse America, training and information: http://www.preventchildabuseillinois.org/#!sbs/c1uvp

3. Product Safety:
    a. CPSC, *On Safety* Blog detailing recall notices: http://www.cpsc.gov/onsafety/
    b. Kids in Danger contains trainings, a newsletter, and a blog: http://www.kidsindanger.org

SECTION EIGHT:

Recommendations for Trauma, Child Abuse and Neglect, and Domestic Violence

Recommendations for Trauma, Child Abuse and Neglect, and Domestic Violence

Introduction to Issue

Childhood trauma is defined as "the experience of an event by a child that is emotionally painful or distressful, which often results in lasting mental and physical effects."[119] An estimated 41% of Illinois children have experienced one or more traumatic events. [120] Very young children are at disproportionate risk of experiencing traumatic events; they represent the majority of children who die from child abuse and neglect, are more likely to live in a home with domestic violence, and for the first year of life experience the single most dangerous period of their childhood.[121] A 2007 study looking at the presence of children during domestic violence incidents found that children were present for 43% of domestic violence police calls, that 81% of the children present either heard and/or saw the event, and that 60% of these directly exposed children were less than six years old.[122]

Childhood trauma can disrupt a child's normal development and lead to physical, emotional, cognitive, behavioral and social problems. Research shows that the younger children are when they experience trauma, the more vulnerable they are to its effects on brain development. [123] In addition, exposure to multiple traumatic events increases the likelihood that a child will experience trauma. Research also suggests that cumulative exposure to traumatic events puts one at an increased risk for chronic ill health. [124] We must also keep in mind that culture can affect the meaning that a child or family attributes to specific types of traumatic events and may also greatly influence the ways in which children and their families respond to traumatic events including how they experience and express distress, disclose personal information, receive support, and seek help. While the effects of early childhood trauma have the potential to be extensive, early identification and treatment can minimize long-term negative outcomes for young children. Research has shown that sensitive and responsive caregiving from child care providers can moderate a child's emotional and physiological stress responses. [125]

Early care and education providers play a significant role in the lives of young children as more and more children in Illinois are cared for outside their homes in early childhood settings. Early care and education providers are uniquely positioned to support young children and families: they come into regular and direct contact with

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[119] Illinois Childhood Trauma Coalition. *What is Childhood Trauma?* <http://lookthroughtheireyes.org/what-is-childhood-trauma/>.

[120] Sacks, Vanessa Harbin, David Murphey and Kristin Anderson Moore. "Adverse Childhood Experiences: National and State Level Prevalence." *Child Trends* Pub. 2014-28 (Jul 2014).

[121] "The Impact of Trauma and Infants." *Children's Mental Health eReview,* Child Welfare Series Jan 2012. University of Minnesota.

[122] Fantuzzo, J., and R. Fusco. "Children's Direct Sensory Exposure to Substantiated Domestic Violence Crimes." *Violence and Victims* 22.2 (2007): 158-171 cited in Zeanah, Jr. Charles (Ed). Handbook of Infant Mental Health, 3rd Ed (2009): 198.

[123] Weber, DA and CR Reynolds. "Clinical Perspectives on Neurobiological Effects of Psychological Trauma." *Neuropsychology Review* 14.2 (2004): 115-129.

[124] Dube, SR, et al. "Cumulative Childhood Stress and Autoimmune Disease in Adults." *Psychosomatic Medicine* 71.2 (2009): 243-250.

[125] National Scientific Council on the Developing Child. "Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3." Center on Developing Child, Harvard University (2005/2014).

young children and their families and are often seen as nurturing caretakers to young children, and they may have access to resources and best practices which can help young children's healthy development. Through nurturing and caring relationships, early care and education providers can help build resiliency and ameliorate the effects of trauma. Therefore, it is important to ensure that programs within Illinois' early childhood systems are appropriately prepared to serve children who may have been exposed to trauma whether through child abuse and neglect, domestic violence, community violence, forced separation from a parent or caregiver or other circumstances. However, gaps exist in Illinois' early childhood systems around trauma-informed training for staff and the awareness and availability of resources for staff, young children, and their families. Accordingly, the Health Subcommittee of the Systems and Integration and Alignment Committee proposes the following recommendations organized by the categories of Policy, Training, Support and Information.

Recommendations (Policy, Training, Support, and Information)

POLICY:

1. The ELC, ICTC, ICMHP, and other Illinois early childhood trauma experts should jointly create a set of developmentally informed and culturally responsive policies and procedures for programs that work with young children exposed to trauma.

2. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.

3. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should require that persons working in these organizations or programs receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.

TRAINING:

1. ICTC, ICMHP, ICAAP, Erikson Institute, the Ounce Institute, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood mental health and trauma experts should work with INCCRRA to review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.

2. DCFS should revise the current mandated reporter training to include more comprehensive information on how to recognize signs of abuse and neglect, understand the impact of abuse and neglect on brain and child development, and respond if an instance of abuse or neglect is revealed.

3. ICTC, ICMHP, ICAAP, Erikson Institute, the Ounce Institute, and other Illinois early childhood mental health and training experts should work together with INCCRRA to create a training on self-care to be available to early care and education staff members (if such a training does not currently exist) to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.

SUPPORT:

1. IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services should work with ICMHP to ensure that programs are aware of and know how to access mental health consultation and treatment providers in order to support staff members, young children, and their families.

2. DCFS should provide early care and education providers with automatic access to the SPD of service agencies and programs throughout Illinois so that providers can locate mental health resouces in their communities to support young children and families. SPD also contains information on early childhood, parenting, substance abuse, and domestic violence services. This database searches all available resources for the closest provider that offers the services requested.

3. State agencies funding mental health consultation should extend mental health consultation services to staff members as a resource to help manage their emotional well-being in the event of a traumatic event experienced in the early care and education setting or within the community where the program is located.

INFORMATION:

1. State agencies should promote state-wide dissemination of ICTC's public messaging campaign *Look Through Their Eyes*.

2. State agencies should promote state-wide dissemination of fact sheets from ICTC and Strengthening Families Illinois on trauma (including information on child abuse and neglect and domestic violence) and promoting protective factors to early care and education providers, home visitors and EI providers for their own education and for distribution to staff and families.

Recommendations for Trauma, Child Abuse and Neglect, and Domestic Violence

Existing Resources

1. ICTC has a *Gray Matters* childhood trauma training that could be adapted specifically for persons working in early childhood systems. ICTC also has provided the "Childhood Exposure to Violence and Trauma" training to HS teachers and staff, and "The Impact of Trauma" training to child care workers: http://illinoischildhoodtrauma.org

2. ICAAP is the lead agency on the Promoting Resiliency of Trauma-Exposed Communities Together (PROTECT) Initiative and has gathered data on trauma training in Illinois. ICAAP is currently developing a trauma training for home visitors that could be adapted for a broader audience: http://illinoisaap.org/projects/early-childhood-development-initiatives/protect/

3. Caregiver Connections provides early childhood mental health consultation support for childcare providers: http://caregiverconnections.org/

4. National Child Traumatic Stress Network (NCTSN): http://www.nctsn.org/trauma-types/early-childhood-trauma
   NCTSN's Self-Care for Educators tips: http://www.nctsnet.org/sites/default/files/assets/pdfs/CTTE_SelfCare.pdf

5. ZERO TO THREE is a national, non-profit organization that provides parents, professionals, and policymakers the knowledge and know-how to nurture early development: http://www.zerotothree.org

6. Hope and Healing: A Caregiver's Guide to Helping Young Children Affected by Trauma (Zero to Three Early Care Library) Kathleen F. Rice and Betsy M. Groves, November 2005

7. National Center on Domestic Violence, Trauma & Mental Health has a training curriculum on children and families affected by domestic violence, child abuse, and other trauma: http://promising.futureswithoutviolence.org/advancing-the-field/researc-informed-strategies/national-center-on-domestic-violence-trauma-mental-health/

8. Substance Abuse and Mental Health Services Administration (SAMHSA) has various resources around childhood trauma and has looked into elements that are included in introduction to trauma trainings: http://www.samhsa.gov/

9. Trainings relating to domestic violence:
    a. http://www.instituteforsafefamilies.org/sites/default/files/isfFiles/CHANCE-Curriculum.pdf
    b. http://www.futureswithoutviolence.org/userfiles/file/HealthCare/HV%20Oct%2017%20Webinar%20FINAL.pdf
    c. http://www.futureswithoutviolence.org/section/our_work/health/_webinars/_2_19_13

10. National Center on Domestic Violence, Trauma and Mental Health develops and promotes accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being: http://www.nationalcenterdvtraumamh.org/

11. DCFS SPD contains information on services that are available for children and families, including mental health, early childhood, parenting, substance abuse, and domestic violence. This database searches all available resources for the closest provider that offers the services requested: https://illinoisoutcomes.dcfs.illinois.gov

Additional Resources:

National Training Institute (NTI) for Child Care Health Consultants

http://nti.unc.edu

These materials are from a National Healthy Child Care America Cooperative Agreement Program, MCHB-funded from 1997-2013, train-the-trainer program to address the needs of child care health consultants.

Sample Curricula and Toolkits:

Child Maltreatment

Module: Caring for Children Who are Maltreated: Training Module (Version 3)
Toolkit: Caring for Children Who are Maltreated (slides)
Toolkit: Caring for Children Who are Maltreated Trainer's Guide (version 1)

Children with Special Health Care Needs

Module: Caring for Children with Special Needs: Training Module (version 4)
Toolkit: Children with Special Needs Trainer's Guide (version 1)
Toolkit: Caring for Children with Special Needs (slides)

Environmental Health (including lead)

Module: Environmental Health in Child Care: Lead (version 2)
Module: Environmental Health in Child Care: Training Module (version 4)
Toolkit: Environmental Health in Child Care: Trainer's Guide (version 1)
Toolkit: Environmental Health in Child Care (slides)
Toolkit: Environmental Health in Child Care: Lead - Trainer's Guide (version 1)
Toolkit: Environmental Health in Child Care: Lead (slides)

Infectious Diseases

Module: Infectious Disease in Child Care Settings: Training Module (version 3)
Module: Infectious Disease in Out of Home Child Care, Part I
Module: Infectious Disease in Out of Home Child Care, Part II
Module: Infectious Disease in Out of Home Child Care, Part III
Toolkit: Infectious Disease in Child Care Settings (slides)
Toolkit: Infectious Disease in Child Care Settings Trainer's Guide (version 1)

Injury Prevention A and B

Module: Injury Prevention in Child Care Part A: Playground... (version 4)
Module: Injury Prevention in Child Care Part B: Common... (version 4)
Module: Matching Children and Play Equipment
Module: Playground Surfacing Materials: ADA-Approved and Non-Approved
Toolkit: Injury Prevention in Child Care: Playground... (slides)
Toolkit: Injury Prevention in Child Care Part A: Playground Trainer's Guide (version 1)
Toolkit: Injury Prevention in Child Care Part B: Common... (slides)
Toolkit: Injury Prevention in Child Care Part B: Common... Trainer's Guide (version 1)

Additional Resources:

Mental Health

Module: Mental Health in the Child Care Setting – Supporting… (version 3)
Module: Early Brain Development: Implications for Early Childhood Programs
Toolkit: Mental Health in the Child Care Setting – Supporting… Trainer's Guide (version 1)
Toolkit: Mental Health in the Child Care Setting (slides)

Nutrition and Physical Activity

Module: Nutrition and Physical Activity in Child Care (version 5)
Module: Making Food Healthy and Safe for Children (2nd edition)
Toolkit: Nutrition and Physical Activity in Child Care (slides)
Toolkit: Nutrition and Physical Activity in Child Care Trainer's Guide

Oral Health

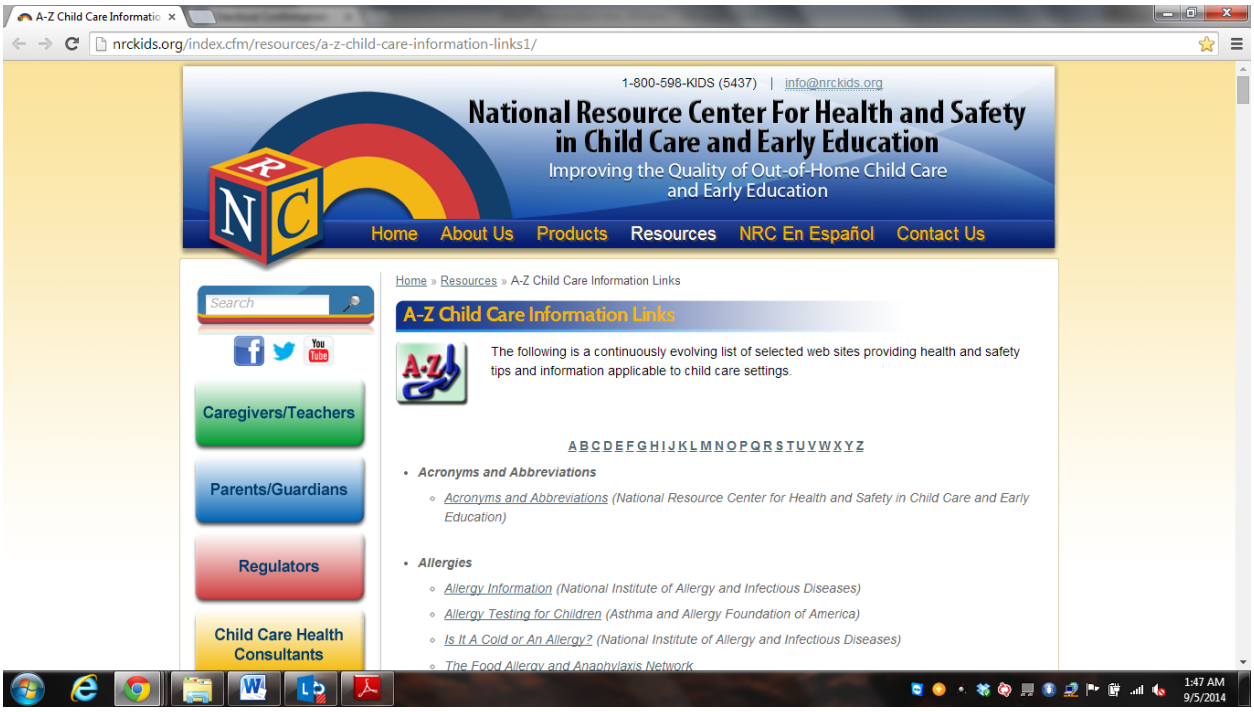
Module: Caring for Children's Oral Health (version 5)
Toolkit: Healthy Smiles: Caring for Children's Oral Health (slides)
Toolkit: Healthy Smiles: Caring for Children's Oral Health Trainer's Guide (version 1)
Toolkit: Primary Teeth Eruption Chart
Toolkit: My Survey: Which Toothpaste do You Use?

Additional Resources:

National Resource Center for Health and Safety in Child Care and Early Education (NRC)

http://nrckids.org/index.cfm/resources/a-z-child-care-information-links1/

NRC shares selected web sites providing health and safety tips and information applicable to child care settings:



Additional Resources:
Healthy Child Care America

Healthy Child Care America

http://www.healthychildcare.org/resourcelibrary.html

Healthy Child Care America has a user-friendly search tool for its resource library:

APPENDIX A

Health Issue Matrix (template)

	Early Intervention	**0-3 Center-based ECE**	**3-5 Center-based ECE**	**Licensed Home Based ECE**	**License Exempt Home Based ECE**	**Home visiting**
Health Issue: _____	Provider Role(s): Training received: Gaps?:	Provider Role(s): Training received: Gaps?:	Provider Role(s): Training received: Gaps?:	Provider Role(s): Training received: Gaps?:	Provider Role(s): Training received: Gaps?:	Provider Role(s): Training received: Gaps?:

APPENDIX B

Health Issue Quartile Ranking (template)

Health Issues	Rank Health Issues
• Abuse/Neglect • Asthma/Second Hand Smoke • Child Development (physical, cognitive and social emotional) • Chronic health conditions • Domestic Violence • Hearing • Insurance Access • Lead poisoning • Maternal/Paternal mental health • Obesity Prevention • Oral Health • PCP/Medical Home • Product Safety/SIDS/Shaken Baby • Substance Abuse • Trauma • Vision	**Top Quartile** • _____ • _____ • _____ • _____ **Second Quartile** • _____ • _____ • _____ • _____ **Third Quartile** • _____ • _____ • _____ • _____ **Bottom Quartile** • _____ • _____ • _____ • _____

APPENDIX C

Health and Early Childhood Glossary of Terms

504 Plan:
A 504 Plan refers to Section 504 of the Rehabilitation Act as well as Americans with Disabilities Act, which specifies that no one with a disability can be excluded from participating in federally funded programs or activities, including elementary, secondary, or postsecondary schooling.

American Academy of Pediatrics (AAP):
The AAP is a national, professional membership organization of primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to attaining optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

American Society for Testing and Materials (ASTM):
The ASTM is an international standards organization that develops and publishes voluntary consensus technical standards for a wide range of materials, products, systems, and services.

Body Mass Index (BMI):
BMI is a measure of body fat based on height and weight.

Caring For Our Children (CFOC):
CFOC is a collection of 686 national standards that represent the best evidence, expertise, and experience in the country on quality health and safety practices and policies that should be followed in today's early care and education settings. It is authored by the AAP, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education.

Centers for Disease Control and Prevention (CDC):
The CDC is one of the major operating components of the Department of Health and Human Services. Its role is to protect the U.S. from health, safety, and security threats, both domestic and foreign and whether diseases begin at home or abroad, are chronic or acute, curable or preventable, or human error or deliberate attack. It is also the primary source of health data in the U.S.

Chicago Department of Family and Support Services (DFSS):
DFSS is the City of Chicago agency that provides resources, such as food assistance, shelter and clothing, and referrals for specialized services, such as job training assistance, at six locations across the city.

Child and Adult Care Food Program (CACFP):
CACFP is a program of the USDA's Food and Nutrition Service and is authorized by Section 17 of the National School Lunch Act. Child care programs eligible to participate in CACFP include public and private nonprofit child care centers, HS programs, and other licensed child care programs. CACFP targets its support for children most in need and provides 100% or sliding scale reimbursement rates to programs.

APPENDIX C

Child Care:
According to Section 2.05 of the Illinois Administrative Code, a child care facility refers to any individual, group of individuals, or agency that receives or arranges for care or placement of one or more children, unrelated to the operator of the facility, apart from the parents. Within the state of Illinois, it can include a Licensed Child Care Center; Licensed-Exempt Child Care Center; Licensed Family Child Care Home; Licensed-Exempt Family Child Care Home; In-Home Care; HS; EHS; and PFA.

Child Care Assistance Program (CCAP):
CCAP provides low-income, working families with access to quality, affordable child care that allows them to continue working and contribute to the healthy development of the child. Families are required to cost-share on a sliding scale based on family size, income, and number of children in care.

Child Care Resource and Referral (CCR&R):
A CCR&R is an information and referral service for families, child care providers, employers, and communities that provides consumer education resources to assist families in selecting a provider in addition to summaries of DCFS licensing standards for child care. It also offers child care providers a referral database and statistical data on child care services, as well as educational training and support services.

Child Death Review Team (CDRT):
There are eight mandated regional committees tasked with the review of all cases involving a death of a minor child that is under the supervision of DCFS or has had an active case within the last 12 months. The purpose of these committees is to identify ways in which the system can be improved to ensure the safety of children whose families are involved with DCFS.

Child and Family Connections (CFC):
CFC sites are the system points of entry for state EI services. There are 25 CFC sites in Illinois. CFC coordinators support families by providing services such as obtaining screenings and evaluations to determine eligibility for EI, assessing service needs of eligible children, planning for needed services, facilitating and monitoring IFSP development, and choosing credentialed providers.

Children's Health Insurance Plan (CHIP):
CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In Illinois, services include routine check-ups, immunizations, and dental care, as well as specialized doctor visits, prescription medications, and hospital care when an illness occurs.

Consumer Product Safety Commission (CPSC):
CPSC is charged with protecting the public from unreasonable risks of injury or death and is associated with ensuring the safety of consumer products, such as toys, cribs, power tools, cigarette lighters, and household chemicals.

APPENDIX C

Continuing Education Unit (CEU):
CEUs are a measure used in continuing education programs, particularly those required in a licensed profession, for the professional to maintain the license or to receive certification. They show evidence of completion of continuing education requirements mandated by certification bodies, professional societies, or governmental licensing boards and also provide employers with information on training pertinent to particular occupations.

Early Childhood Hearing Outreach Initiative (ECHO):
The ECHO Initiative of the EHDI Program focuses on extending the benefits of periodic hearing screening to young children in a variety of health and education settings. The Illinois EHDI program currently works with EHS and PAT programs providing technical assistance and trainings.

Early Head Start (EHS):
The 1994 Reauthorization of the Head Start Act created the EHS Program, which targets families with incomes below the Federal Poverty Level with children aged zero to three. Offering comprehensive child development and family support services, the program aims to offer care-giving to infants and toddlers to promote their physical, cognitive, social, and emotional development; provide support to parents so that they can successfully fulfill their roles as primary caregivers and teachers for their young children while also achieving self-sufficiency; and work with communities to create environments that support the needs of children and families. An EHS Program may be center based, home based, family-child care services, or a combination of each.

Early Hearing Detection and Intervention (EHDI):
EHDI refers to the practice of screening every newborn for hearing loss prior to hospital discharge. Infants not passing the screening receive diagnostic evaluation before three months of age and, when necessary, are enrolled in early intervention programs by six months of age. In Illinois, the program is a collaboration between IDHS, IDPH, and the University of Illinois at Chicago's Division of Specialized Care for Children and provides services such as training for providers on screening and referral, parent information, diagnostic evaluation, and follow-up.

Early Intervention (EI):
EI, also referred to as Part C of the Individuals with Disabilities Education Act, is a system that provides coordinated, comprehensive, and multidisciplinary social and developmental services to children under the age of three who have a developmental delay or disability or who are at risk of a delay. CFC sites are the system points of entry for state-provided EI services and provide screenings and evaluations to determine eligibility for EI, assess service needs of eligible children, plan for needed services, and choose among credentialed providers.

Early Learning Council (ELC):
The ELC is a public-private partnership created by Public Act 93-380 with the intention to strengthen, coordinate, and expand programs and services for children birth to five throughout Illinois. Membership includes senior state officials and non-government

stakeholders appointed by the Governor and works to ensure a comprehensive, statewide early learning system (preschool, child care, Head Start, health care, and support programs for parents).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT):
EPSDT is the child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive dental, mental health, developmental, and specialty services.

ExceleRate:
ExceleRate Illinois is the QRIS framework for Illinois, establishing a set of standards to judge early childhood providers and encouraging programs to strive toward higher levels of care. It covers licensed child care centers, PFA programs, center-based PI Programs, and HS and EHS Programs. ExceleRate evaluates programs according to the domains of teaching and learning, family and community engagement, leadership and management, and qualifications and continuing education. Providers that have been evaluated receive one of four circles of quality: licensed, bronze, silver, or gold.

Enhancing Developmentally Oriented Care Project (EDOPC):
Established as a partnership between the Advocate Health Care Healthy Steps Program and ICAAP, EDOPC is a resource for healthcare providers in Illinois. EDOPC works to improve the delivery and financing of preventive health and developmental services for children birth to age three and offers online training in developmental screening, social-emotional screening, perinatal maternal depression screening, domestic violence screening, and care coordination.

Gateways to Opportunity:
Gateways is the early childhood professional development portal for the State of Illinois. The system establishes the skills and experiences that early childhood providers need, as well as certifications such as the Early Childhood Education, Infant Toddler, School-Age and Youth Development, and Director Credential. Gateways also provides information on where early childhood providers can participate in trainings and offers scholarships to cover some of the costs of participation.

Governor's Office of Health Innovation and Transformation (GOHIT):
GOHIT is responsible for directing Illinois' health reform initiatives, particularly those related to the State's Alliance for Health Innovation Plan. The Alliance for Health brought together all of the state's health insurance plans, large provider organizations, public health practitioners and more than 80 business, consumer, provider and association stakeholders, to identify the innovations needed to achieve better health for residents, improve the effectiveness of the delivery system, and lower costs so health care and insurance is affordable for everyone in the state.

Head Start (HS):
Created in 1965 as part of the Johnson Administration's War on Poverty, HS is a federal program that works to promote school readiness for low-income children. The program

aims to support children's growth in language and literacy, cognitive development, physical development, social-emotional development, and approaches to learning. HS programs also provide health, nutrition, and social support services to participating families in a culturally sensitive manner and emphasize the role of parents as the first and most important teachers for their children. Local agencies, including schools, social service organizations, and community-centered non-profits administer the program and participating families can receive program services in their homes, in family child care homes, and in centers or schools.

Home visiting:
Evidence-based home visiting programs provide voluntary support services to women who are pregnant or have a child aged birth to five. During home visits, parents receive information on child growth and development, are offered coaching on parenting skills and ways of creating a safe and stimulating learning environment for their children, and are linked to other health and social support services. The outcomes of home visiting services depend on the type of model used but can include improved maternal and child health; the prevention of child injuries, abuse, and maltreatment; increased school readiness; reduction in domestic violence; and increased maternal self-sufficiency. Types of models include Healthy Families America, Parents As Teachers, Nurse Family Partnership, and Prevention Initiative models through EHS.

Illinois Chapter of the American Academy of Pediatrics (ICAAP):
ICAAP is the Illinois Chapter of the national AAP (see AAP).

Illinois Childhood Trauma Coalition (ICTC):
ICTC is composed of over 80 public and private organizations dedicated to promoting the prevention and treatment of childhood trauma. Taking a public health approach to the evolving understanding of the nature and impact of childhood trauma, the mission of the ICTC is to expedite the integration of this wisdom into public awareness and the array of systems that serve children and families in Illinois.

Illinois Children's Mental Health Partnership (ICMHP):
The ICMHP is committed to improving the scope, quality and access of mental health programs, services and supports for Illinois children. It is composed of experts, organizations, and stakeholders in the field of mental health and provides advocacy, written publications, and resources around children's mental health topics and issues.

Illinois Department of Child and Family Services (DCFS):
DCFS is the Illinois government agency responsible for preventing child abuse and neglect. The department works to protect children who are reported to be abused or neglected; increase families' capacity to safely care for their children; provide for the well-being of children in DCFS custody; provide appropriate, permanent families for those children who cannot safely return home; support early intervention and child abuse prevention activities; and work in partnership with communities to keep children safe.

APPENDIX C

Illinois Department of Healthcare and Family Services (HFS):
HFS is the state agency responsible for providing healthcare coverage for children and adults who qualify for Medicaid. It oversees the Illinois All Kids Program, which aims to provide comprehensive health coverage for children from families unable to afford private insurance.

Illinois Department of Human Services (IDHS):
IDHS is the state agency that is responsible for the coordination and provision of social services in Illinois. The agency implements community health and prevention programs; provides supports for eligible low-income individuals by linking them with educational and employment opportunities and supports; and manages service systems that treat persons with physical, mental, and developmental needs.

Illinois Department of Public Health (IDPH):
IDPH is the state agency that protects residents and visitors through the prevention and control of disease and injury. It provides over 200 programs that include services such as restaurant inspection; vaccinations to children; testing of food, water, and drugs; licensing to ensure quality health care; investigations to control the outbreak of infectious diseases; collection of health statistics; and more.

Illinois Network of Child Care Resource and Referral Agencies (INCCRA):
INCCRRA is a statewide organization which, in partnership with its sixteen local CCR&Rs, is a recognized leader, catalyst, and resource for making high-quality, affordable early care and education and school-age care options available for children and families in Illinois. Gateways for Opportunity is managed by INCCRA.

Illinois State Board of Education (ISBE):
ISBE is the state agency that provides leadership, assistance, resources, and advocacy so that every student is prepared to succeed in careers and postsecondary education, and share accountability for doing so with districts and schools.

Individualized Education Plan (IEP):
IEPs outline the specialized services and educational supports for children ages three to 22 that have been identified as having special needs, concentrating on how to create the educational environment in which a child can learn. An IEP meeting must be held within 30 days of determining a child's eligibility.

Individualized Family Service Plan (IFSP):
IFSPs are written plans developed for and in consultation with families with children aged zero to three who are a part of the Early Intervention system. The IFSP must be written within 45 days of a child being referred for EI and must include a description of family strengths, needs, concerns, priorities, and resources. The IFSP additionally lists out the family's goals for their child. This information structures the types of services that the family and child will receive as part of the EI program. The IFSP must be reviewed every six months and the services can continue if a child remains eligible until he or she ages out at 3 years old.

APPENDIX C

Individuals with Disabilities Education Act (IDEA):
IDEA is a law ensuring services to children with disabilities and governs how states and public agencies provide EI, special education, and related services eligible infants, toddlers, and children with disabilities. Infants and toddlers with disabilities (birth to two) and their families receive EI services under IDEA Part C and children and youth (ages three to 21) receive special education and related services under IDEA Part B.

Local Education Agency (LEA):
The Federal Elementary and Secondary Education Act defines an LEA as a public board of education within a state that has administrative authority over the public elementary and secondary schools within a region.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV):
The MIECHV program supports pregnant women and families and helps parents of children from birth to age five develop the skills they need to raise children who are physically, socially, and emotionally healthy and ready to learn. The U.S. DHHS funds states to develop and implement voluntary, evidence-based home visiting programs using models that are proven to improve child health and to be cost effective.

Memorandum of Understanding/ Memorandum of Agreement (MOU/MOA):
An MOU or MOA is an agreement between two or more parties. Within the context of early childhood, MOUs can be used to facilitate cooperation and information sharing so that providers operating in different systems can collaborate more effectively and better address the needs of children.

National Association for the Education of Young Children (NAEYC):
NAEYC promotes high-quality learning for all children aged birth through eight by connecting practice, policy, and research. The organization has an established national accreditation system setting professional standards for early childhood education programs, allowing families to find high-quality programs for their children. They also provide professional development opportunities for providers by offering online learning programs, training-of-trainers on early childhood subjects, and annual conferences and workshops.

National Center for Children's Vision and Eye Health (NCCVH)
NCCVH engages partners in ophthalmology, optometry, pediatrics, and public health to mobilize and utilize emerging technology protocols and instruments as well as encourage face-to-face discussion and engagement by all involved. Collectively, this group is developing the infrastructure and best practices needed to improve the continuum of eye health care for young children.

Office of Early Childhood Development (OECD):
OECD is an Illinois state entity that promotes coordinated and integrated early childhood systems and programs. OECD manages the ELC; oversees ExceleRate Illinois and the Innovation Zones; collects data for policy and program changes; acts as an

information resource for families, programs, and communities; and facilitates cross agency collaboration.

Otoacoustic Emissions (OAE):
OAEs are sounds given off by the inner ear when the cochlea is stimulated by a sound. When sound stimulates the cochlea, the outer hair cells vibrate. The vibration produces a nearly inaudible sound that echoes back into the middle ear, which can be measured with a small probe inserted into the ear canal. The OAE can detect blockage in the outer ear canal, as well as the presence of middle ear fluid and damage to the outer hair cells in the cochlea.

Preschool for All (PFA):
Funded by ISBE, the PFA program emphasizes the relationship among early childhood education, parenting education and involvement, and future success in school. Delivered through local school districts, it focuses on providing high-quality educational programs for children ages three and four who are determined to be at risk of academic failure.

Prevention Initiative (PI):
Funded by ISBE, the PI Program offers coordinated services to at-risk infants, toddlers, and their families (children from birth to three) through a network of child and family service providers who conduct home visits, workshops, and playgroups. The program provides case management, instruction on child development, and developmental screenings.

Quality Rating Improvement System (QRIS):
A QRIS is a means of identifying, improving, and communicating the level of care for children in childcare and educational settings. (See ExceleRate).

Shaken Baby Syndrome (SBS):
SBS is defined by the CDC as a form of abusive head trauma (AHT) and inflicted traumatic brain injury (ITBI), and as a preventable and severe form of physical child abuse. It results from violently shaking an infant by the shoulders, arms, or legs. SBS may result from both shaking alone or from impact (with or without shaking). The resulting whiplash effect can cause bleeding within the brain or the eyes.

Sleep Related Infant Deaths:
A lay term used to describe a list of unexpected infant deaths including SIDS, Accidental Suffocation, Sleep Associated Suffocation and Strangulation, and SUID.

Statewide Provider Database (SPD):
The SPD is an online searchable catalogue of community resources for families and children. A service of DCFS, both DCFS and non-DCFS staff can use the database as a resource.

APPENDIX C

Sudden Infant Death Syndrome (SIDS):
SIDS is defined by the CDC as the sudden and unexpected death of an infant between 28 days and one year of age that remains unexplained after three criteria have been reviewed: a complete autopsy; a review of the case history including all appropriate records (birth-related problems and the infant's growth, development, immunization, and medical history); and a death scene investigation.

Sudden Unexpected Infant Death (SUID):
SUID is defined by the CDC as deaths in infants less than one year of age that occur suddenly and unexpectedly, and whose cause of death is not immediately obvious prior to investigation. After a thorough case investigation, many of these sudden unexpected infant deaths may be explained. Poisoning, metabolic disorders, hyper or hypothermia, neglect and homicide, and suffocation are all explainable causes of SUID.

Traumatic Brain Injury (TBI):
TBI is a non-degenerative, non-congenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness. In infants this is sometimes caused by shaking.

World Health Organization (WHO):
WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends.

United States Department of Agriculture (USDA):
The USDA is the federal executive department responsible for developing and executing federal government policy on farming, agriculture, forestry, and food. It aims to meet the needs of farmers and ranchers, promote agricultural trade and production, work to assure food safety, protect natural resources, foster rural communities and end hunger in the US and abroad.

US Prevention Services Task Force (USPSTF):
The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine and works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Members come from the fields of preventive medicine and primary care, including internal medicine, family medicine, pediatrics, behavioral health, obstetrics and gynecology, and nursing.

APPENDIX D

Recommendations by Actor

Illinois Department of Children and Family Services (DCFS)

Health Issue	Category	Recommendation
Chronic Health Conditions	Policy	Extend 89 Illinois Administrative Code §407.250(c)(9) to require that all child care providers keep an updated medical action plan on file for any child with a chronic illness.
Chronic Health Conditions; Immunizations	Policy	Amend the Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to require that center-, home-, and school-based early care and education programs update each child's Certificate of Health Examination annually.
Chronic Health Conditions	Policy	Amend Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to require that all early care and education systems provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms.
Chronic Health Conditions	Policy	Amend the Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to allow certain early care and education settings to stock undesignated epinephrine auto-injectors.
Chronic Health Conditions	Training	Provide early care and education providers with training in the use of action plans, identifying the first signs of allergic reactions or chronic health issues and communicating sensitively to parents about common chronic health issues and appropriate follow-up care.
Developmental and Social-Emotional Screening	Policy	Require social-emotional screening in programs that currently require regular developmental screening.
Developmental and Social-Emotional Screening	Policy	Explore the possibility of Medicaid reimbursement for developmental and social-emotional screening for early care and education programs who are not Medicaid providers.
Developmental and Social-Emotional Screening	Policy	Require developmental (including social-emotional screening) in both 406 licensing standards for licensed family child care providers and 407 licensing standards for center based child care providers.
Developmental and Social-Emotional Screening	Training	Offer training on social-emotional screening as regularly as training on developmental screening to early childhood providers and Child Find screening teams.
Developmental and Social-Emotional Screening	Training	Ensure that all training on developmental and social-emotional screening includes how to talk with parents about concerns and delays and how to use the MOUs and resource guide developed by the Special Education Subcommittee as well as how to use guidelines on best practices for referral, feedback, and lines of communication.
Developmental and Social-Emotional Screening; Parental Depression; Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.
Developmental and Social-	Information	Distribute the MOUs and resource guide developed by the Special Education Subcommittee to

APPENDIX D

Health Issue	Category	Recommendation
Emotional Screening		all early care and education providers.
Developmental and Social-Emotional Screening	Information	When developed, disseminate guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Developmental and Social-Emotional Screening	Information	Ensure that handbooks and guidelines for parents that outline parent's rights and program responsibilities are updated when needed, widely distributed to early care and education programs, available at all trainings on developmental and social-emotional screening, and that the links on their websites to handbooks and guidelines for parents are visible and easily found.
Obesity Prevention	Policy	Update 89 Illinois Administrative Code Rule 406 to align with the nutrition, physical activity, and screen time standards in Rule 407.
Obesity Prevention	Policy	Amend 89 Illinois Administrative Code Rule 407 to include the recommendations from the Systems Integration and Alignment Committee, Health Subcommittee that were previously submitted, but not accepted, including: a. Programs should avoid serving concentrated sweets, such as candy, cupcakes, donuts, cookies, and other sugary foods. b. Children ages 12 months or older should participate in 60 minutes of age-appropriate moderate to vigorous physical activity per day. For children ages three (36 months) and older, at least 30 of the 60 minutes shall be structured and guided moderate to vigorous physical activity; the remainder of the physical activity may be concurrent with other active play, learning, and movement activities. i. Structured and guided physical activity shall be facilitated by teachers and/or child care providers and shall promote basic movement, creative movement, motor skills development, and general coordination. ii. Children attending a program less than six hours shall be scheduled to participate in a proportionate amount of such activities. c. Children attending a program less than six hours shall be scheduled to participate in at least one occasion of age-appropriate outdoor time. d. When screen time media is used, whether interactive or passive, it should be free of food and beverage advertising and brand placement.
Oral Health	Policy	Amend 89 Illinois Administrative Code Rule 407 to include the recommendations from the Systems Integration and Alignment Committee, Health Subcommittee that were previously submitted, but not accepted, including: a. Require early care and education programs to encourage parents to establish a dental home for their child within six months after the first tooth erupts or by one year of age, whichever is earlier. b. Starting at birth, early care and education staff should clean an infant's gums using water and a soft infant toothbrush or cloth preferably after meals. c. Require that all children with teeth should brush or have their teeth brushed at least once during the hours the child is in care if care is provided for five or more hours per day,

APPENDIX D

Health Issue	Category	Recommendation
		preferably after a meal or a snack. The staff should either brush the child's teeth or supervise as the child brushes his/her own teeth and brushing should be supervised until the child can reliably rinse and spit out excess toothpaste (usually at six years of age). The caregiver/teacher should teach the child the correct method of tooth brushing when the child is capable of doing this activity. d. Extend the current standard in Rule 407, Section 407.240 ("Evening, Night, Weekend, and Holiday Care") to all licensed child care centers, regardless of center business hours and days of operation: Each child shall have an individual toothbrush furnished either by the center or the child's parents. e. Require that programs should not allow the sharing of a toothbrush with a child due to the risk of promoting early colonization of the infant oral cavity with Streptococcus mutans, bacteria that causes early childhood caries. f. Require that staff use a "smear" of toothpaste to brush the teeth of a child less than two years of age. For the two to five year old, staff should dispense a "pea-size" amount of toothpaste. g. Since all public water systems in Illinois are optimally fluoridated, children should drink water from the tap in order to reduce the risk of dental caries and tooth decay.
Oral Health	Policy	Update 89 Illinois Administrative Code Rule 406 to align with the oral health and hygiene standards in Rule 407.
Oral Health	Information	Promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice.
Parental Depression	Policy	Require that persons working with infants and toddlers in early childhood systems receive training on the effects of parental depression.
Parental Depression	Policy	Require that all early care and education programs that already screen for maternal/paternal depression have protocols in place for immediate referral should there be severe indications of depression or suicide ideation.
Parental Depression	Information	Disseminate information on maternal and paternal depression and the impact on child development to early care and education providers.
SIDS, SBS, and Product Safety	Policy	Include deaths of a minor child in a licensed or licensed-exempt child care center or home in the CDRT system.
SIDS, SBS, and Product Safety	Policy	Link directly with the CPSC's recall list so that it is always complete and accurate and require licensed providers to sign up for alerts from the CPSC.
SIDS, SBS, and Product Safety	Policy	Establish a consistent policy for reviewing equipment safety at every site visit including verification of supporting documentation that products meet current federal manufacturing guidelines set forth by the ASTM.
SIDS, SBS, and Product Safety	Policy	Amend Illinois Administrative Code Rules 407 and 406 to include language in licensing to require that products be used as the manufacturer intended in the instructions.
SIDS, SBS, and Product Safety	Support	Expand the network of licensing representatives so that it includes Product Safety Inspectors.

APPENDIX D

Health Issue	Category	Recommendation
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Require that persons working in early care and education programs receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Revise the current mandated reporter training to include more comprehensive information on how to recognize signs of abuse and neglect, understand the impact of abuse and neglect on brain and child development, and respond if an instance of abuse or neglect is revealed.
Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Provide early care and education providers with automatic access to the SPD of service agencies and programs throughout Illinois so that providers can locate mental health resouces in their communities to support young children and families.
Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Extend mental health consultation services to staff members as a resource to help manage their emotional well-being in the event of a traumatic event experienced in the early care and education setting or within the community where the program is located.
Trauma, Child Abuse and Neglect, and Domestic Violence	Information	Promote state-wide dissemination of ICTC's public messaging campaign *Look Through Their Eyes*.
Trauma, Child Abuse and Neglect, and Domestic Violence	Information	Promote state-wide dissemination of fact sheets from ICTC and Strengthening Families Illinois on trauma (including information on child abuse and neglect and domestic violence) and promoting protective factors to early care and education providers, home visitors and EI providers for their own education and for distribution to staff and families.

Department of Healthcare and Family Services (HFS)

Health Issue	Category	Recommendation
Chronic Health Conditions	Information	Develop and provide information regarding primary care, medical home, and insurance coverage options to DCFS, IDHS, ISBE and the Office of the Governor to disseminate to families with young children in early care and education programs.
Immunizations	Training	Ensure that all program staff, but particularly family support staff and early childhood staff, have knowledge of the importance of establishing a medical home and accessing immunizations, as well as adhering to the CDC's recommended immunization schedule for young children.
Immunizations	Information	Distribute information about the IDPH's immunization information number (800-526-4372) to all families.
Developmental and Social-Emotional Screening	Policy	Require social-emotional screening in programs that currently require regular developmental screening.
Developmental and Social-	Policy	Explore the possibility of Medicaid reimbursement for developmental and social-emotional

APPENDIX D

Health Issue	Category	Recommendation
Emotional Screening		screening for early care and education programs who are not Medicaid providers.
Developmental and Social-Emotional Screening	Training	Offer training on social-emotional screening as regularly as training on developmental screening to early childhood providers and Child Find screening teams.
Developmental and Social-Emotional Screening	Training	Ensure that all training on developmental and social-emotional screening includes how to talk with parents about concerns and delays and how to use the MOUs and resource guide developed by the Special Education Subcommittee as well as how to use guidelines on best practices for referral, feedback, and lines of communication.
Developmental and Social-Emotional Screening; Parental Depression; Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.
Oral Health	Information	Promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice.
Oral Health	Information	Partner with INCCRRA to promote regular (e.g., quarterly) dissemination to early care and education staff of an up-to-date health provider list that includes 1) pediatric dentists and 2) primary care physicians that have been trained through *Bright Smiles from Birth*, an oral health education program for primary care providers.
Parental Depression	Policy	Require that all early care and education programs that already screen for maternal/paternal depression have protocols in place for immediate referral should there be severe indications of depression or suicide ideation.
Parental Depression	Support	Disseminate a list of behavioral health services available through Medicaid, including instructions for accessing these services, to the state agencies for dissemination to all providers.
Parental Depression	Information	Disseminate information on maternal and paternal depression and the impact on child development to early care and education providers.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Require that persons working in early care and education programs receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Extend mental health consultation services to staff members as a resource to help manage their emotional well-being in the event of a traumatic event experienced in the early care and education setting or within the community where the program is located.

APPENDIX D

Illinois Department of Human Services (IDHS)

Health Issue	Category	Recommendation
Chronic Health Conditions	Policy	Require that all EI and home visiting programs keep an updated medical action plan on file for any child with a chronic illness.
Chronic Health Conditions	Policy	Require that all EI and home visiting provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms.
Chronic Health Conditions	Training	Provide early care and education providers with training in the use of action plans, identifying the first signs of allergic reactions or chronic health issues and communicating sensitively to parents about common chronic health issues and appropriate follow-up care.
Immunizations	Training	Ensure that all program staff, but particularly family support staff and early childhood staff, have knowledge of the importance of establishing a medical home and accessing immunizations, as well as adhering to the CDC's recommended immunization schedule for young children.
Immunizations	Information	Distribute information about the IDPH's immunization information number (800-526-4372) to all families.
Immunizations	Information	Provide information regarding primary care and medical home options for families with young children.
Developmental and Social-Emotional Screening	Policy	Require social-emotional screening in programs that currently require regular developmental screening.
Developmental and Social-Emotional Screening	Policy	Explore the possibility of Medicaid reimbursement for developmental and social-emotional screening for early care and education programs who are not Medicaid providers.
Developmental and Social-Emotional Screening	Training	Offer training on social-emotional screening as regularly as training on developmental screening to early childhood providers and Child Find screening teams.
Developmental and Social-Emotional Screening	Training	Ensure that all training on developmental and social-emotional screening includes how to talk with parents about concerns and delays and how to use the MOUs and resource guide developed by the Special Education Subcommittee as well as how to use guidelines on best practices for referral, feedback, and lines of communication.
Developmental and Social Emotional Screening; Parental Depression; Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.
Developmental and Social-Emotional Screening	Information	Distribute the MOUs and resource guide developed by the Special Education Subcommittee to all early care and education programs.
Developmental and Social-Emotional Screening	Information	When developed, disseminate guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Developmental and Social-Emotional Screening	Information	Ensure that handbooks and guidelines for parents that outline parent's rights and program responsibilities are updated when needed, widely distributed to early care and education

APPENDIX D

Health Issue	Category	Recommendation
		programs, available at all trainings on developmental and social-emotional screening, and that the links on their websites to handbooks and guidelines for parents are visible and easily found.
Obesity Prevention	Training	Ensure that a training is created and available for early care and education providers on obesity prevention. The training should align with new requirements in 89 Illinois Administrative Code Rule 407 and include how to talk with families and parents about obesity and changes in child care menus, curriculum, and environments.
Obesity Prevention	Training	Ensure that a training is created and available for families and parents through early care and education programs on obesity prevention in early childhood including importance of regular physical activity, nutrition education, cooking, etc.
Obesity Prevention	Training	Ensure that a training is created and available for children enrolled in early childhood programs to expose them to the importance of regular physical activity, nutrition education, cooking, etc.
Oral Health	Policy	Develop an incentive or funding requirement for programs to demonstrate a collaborative relationship(s) with local dental or primary care provider (e.g. an MOU).
Oral Health	Information	Promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice.
Oral Health	Information	Partner with INCCRRA to promote regular (e.g., quarterly) dissemination to early care and education staff of an up-to-date health provider list that includes 1) pediatric dentists and 2) primary care physicians that have been trained through *Bright Smiles from Birth*, an oral health education program for primary care providers.
Parental Depression	Policy	Require that persons working with infants and toddlers in early childhood systems receive training on the effects of parental depression.
Parental Depression	Policy	Require that all early care and education programs that already screen for maternal/paternal depression have protocols in place for immediate referral should there be severe indications of depression or suicide ideation.
Parental Depression	Information	Disseminate information on maternal and paternal depression and the impact on child development to early care and education providers.
Physical Health screening: Lead	Policy	Explicitly list lead poisoning in 89 Illinois Administrative Code §500, Appendix E "Medical Conditions Resulting in High Probability of Developmental Delay" to guarantee children with lead poisoning automatic eligibility for EI services.
Physical Health Screening: Vision	Training	Work with INCCRRA to provide training for early childhood care providers and educators on vision and eye health, signs of vision problems in children, and state-wide guidelines for finding assistance in addressing the vision health of children ages three to five.
Physical Health Screening: Hearing	Training	Work with INCCRRA, EHDI, and ECHO to provide training for early care and education providers on auditory health, signs of hearing problems in children, and statewide guidelines for finding assistance in addressing the auditory health of children ages zero to three and three to five.

APPENDIX D

Health Issue	Category	Recommendation
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Require that persons working in early care and education programs receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Extend mental health consultation services to staff members as a resource to help manage their emotional well-being in the event of a traumatic event experienced in the early care and education setting or within the community where the program is located.
Trauma, Child Abuse and Neglect, and Domestic Violence	Information	Promote state-wide dissemination of ICTC's public messaging campaign *Look Through Their Eyes*.
Trauma, Child Abuse and Neglect, and Domestic Violence	Information	Promote state-wide dissemination of fact sheets from ICTC and Strengthening Families Illinois on trauma (including information on child abuse and neglect and domestic violence) and promoting protective factors to early care and education providers, home visitors and EI providers for their own education and for distribution to staff and families.

Illinois Department of Public Health (IDPH)

Health Issue	Category	Recommendation
Chronic Health Conditions	Policy	Amend the Illinois Child Health Examination Code §665.140(e) for school-based child care to require that center-, home-, and school-based early care and education programs update each child's Certificate of Health Examination annually.
Chronic Health Conditions	Policy	Amend the Illinois Child Health Examination Code §665.140(e) for school-based child care to require that all early care and education systems provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms.
Chronic Health Conditions	Information	Develop medical action plan guides for DCFS, ISBE, and IDHS to distribute to their programs to show parents how to talk to health care providers about action plans and how to communicate with early care and education providers about their children's chronic health needs.
Immunizations	Policy	Amend the Illinois Child Health Examination Code §665.140(e) for school-based programs administered by ISBE to require that center-, home-, and school-based early care, education and intervention programs update each child's Certificate of Health Examination annually.
Immunizations	Information	Provide information about immunizations and where to get immunizations for families with young children to state agencies for dissemination to all early care and education providers.
Obesity Prevention	Information	In partnership with OECD, ensure the creation and availability of public education (e.g., through a media campaign, published fact sheets, newsletter content) to raise awareness about the early origins of childhood obesity, the short- and long-term effects of obesity on children

APPENDIX D

Health Issue	Category	Recommendation
		ages zero to eight, and the role that early care and education providers and settings can (and should) play in obesity prevention.
Oral Health	Training	Ensure that all early childhood and education program staff have knowledge of: the oral health risk factors for pregnant women and children ages zero to five; best practices around nutrition, water consumption and brushing requirements as outlined by CFOC and the American Academy of Pediatric Dentists, and the importance of establishing a dental home by age one and understand how to help families access a dental home**.**
Oral Health	Information	Promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice.
Physical Health Screening: Lead	Policy	Amend the Lead Poisoning Prevention Act P.A. 94-879 §7(1) to require all early care, education and intervention programs to collect evidence of lead screenings or tests in accordance with the IDPH Childhood Lead Risk Assessment Questionnaire guidelines.
Physical Health Screening: Lead	Information	Develop and distribute materials to all early care and education providers explaining the signs of lead presence in the home as well as early symptoms of lead exposure.
Physical Health Screening: Vision	Policy	Establish an additional certification and recertification option for technicians to conduct vision screenings for children ages three to five only.
Physical Health Screening: Vision	Policy	Authorize early childhood training entities to conduct trainings that qualify for IDPH certification and recertification vision screening option for children ages three to five.
Physical Health Screening: Vision	Policy	Revise vision screening administrative codes (Vision Screening Section 685) to follow the screening protocols recommended and continually assessed by the National Center for Children's Vision and Eye Health.
Physical Health Screening: Vision	Policy	Establish or authorize through another entity an Early Childhood Vision Screening Resource Center to provide ongoing skill supports and technical assistance for certified early childhood vision screeners.
Physical Health Screening: Vision	Training	Work with INCCRRA to provide training for early childhood care providers and educators on vision and eye health, signs of vision problems in children, and state-wide guidelines for finding assistance in addressing the vision health of children ages three to five.
Physical Health Screening: Vision	Training	Develop training for early care and education providers on the state vision screening mandates and disseminate this training through IDHS and ISBE, along with INCCRRA.
Physical Health Screening: Hearing	Policy	Partner with the Illinois EHDI program and its ECHO Initiative to develop a standardized hearing screening protocol for early care and education programs serving children ages zero to three years.
Physical Health Screening: Hearing	Policy	Establish an additional certification and recertification option for technicians to conduct hearing screenings utilizing OAE technology for children ages zero to three years.
Physical Health Screening: Hearing	Policy	Authorize early childhood training entities to conduct trainings that qualify for IDPH certification and recertification hearing screening option for children ages zero to three years as well as three to five years.
Physical Health Screening:	Policy	Establish or authorize through another entity an Early Childhood Hearing Screening Resource

APPENDIX D

Health Issue	Category	Recommendation
Hearing		Center to provide ongoing skill supports and technical assistance for certified early childhood hearing screeners, while partnering with EHDI/ECHO.
Physical Health Screening: Hearing	Training	Partner with EHDI and the ECHO Initiative to develop and provide standardized training, in addition to their current training, to allow for certification and recertification of hearing screeners to screen children zero to three years old.
Physical Health Screening: Hearing	Training	Develop a standardized training and curricula, in addition to the current preschool resources through school-age training, to allow for certification and recertification of vision and hearing screeners for all early care and education programs (zero to five years).
Physical Health Screening: Hearing	Training	Work with INCCRRA to provide training for early care and education providers on auditory health, signs of hearing problems in children, and statewide guidelines for finding assistance in addressing the auditory health of children ages zero to five.
Physical Health Screening: Hearing	Information	Disseminate information on the state hearing screening mandates to IDHS, ISBE, DCFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services.

Early Learning Council (ELC)

Health Issue	Category	Recommendation
Developmental and Social-Emotional Screening	Policy	Develop, with the ICMHP, guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Immunizations; Developmental and Social-Emotional Screening; Physical Health Screening: Lead; Physical Health Screening: Vision	Policy	Recommend through the Data, Research and Evaluation Committee that developmental and social-emotional, vision, and lead screenings, along with immunization documentation be included in the Unified Early Childhood Data System.
Parental Depression	Policy	Examine, with the ICMHP, whether it is appropriate and feasible to conduct maternal/paternal depression screenings in all early care and education programs who do not currently do so and incorporate screenings into programs as appropriate.
Parental Depression	Policy	Identify or develop, with the ICMHP, new models for delivering treatment for depression to parents that capitalize on the unique connections early care and education programs have with families while overcoming structural barriers to depression treatment. The feasibility of utilizing these models in Illinois should be evaluated and strategies to finance and implement them at scale should be developed.
Parental Depression	Training	Work with ICMHP, ICAAP, Erikson Institute, the Ounce Institute, INCCRRA, and other Illinois early childhood mental health and training experts to identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with

APPENDIX D

Health Issue	Category	Recommendation
		parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
Parental Depression	Support	Work with the ICMHP to research the possibility of extending the services provided by the University of Illinois at Chicago Perinatal Consultation Line to early care and education providers. If services cannot be extended, consider establishing a "warm line" that can provide training resources, tools to help with screening and referral, and telephone consultation for providers.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Work with ICTC, ICMHP, and other Illinois early childhood trauma experts to create a set of developmentally informed and culturally responsive policies and procedures for programs that work with young children exposed to trauma.

Erikson Institute

Health Issue	Category	Recommendation
Parental Depression	Training	Work with the ELC, ICMHP, ICAAP, the Ounce Institute, INCCRRA, and other Illinois early childhood mental health and training experts to identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, the Ounce of Prevention Fund, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood mental health and trauma experts, along with INCCRRA, to review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, ICAAP, the Ounce of Prevention Fund, and other Illinois early childhood mental health and training experts, along with INCCRRA, to create a training on self-care to be available to early care and education staff members (if such a training does not currently exist) to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.

Gateways to Opportunity

Health Issue	Category	Recommendation

APPENDIX D

Health Issue	Category	Recommendation
Chronic Health Conditions	Training	Expand the "Welcoming Every Child" training to include more comprehensive information for using action plans to support children with chronic health issues.
Physical Health Screening: Lead	Training	Adapt the IDPH Lead Program's visual lead risk assessment training for early care, education and intervention providers who perform regular home visits in EI or home-based EHS programs.

Home Visiting models and curricula

Health Issue	Category	Recommendation
SIDS, SBS, and Product Safety	Training	Require SIDS, SBS, and Product Safety training for home visitors rather than recommend.

Illinois Children's Mental Health Partnership (ICMHP)

Health Issue	Category	Recommendation
Developmental and Social-Emotional Screening	Policy	Develop, with the ELC, guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Developmental and Social-Emotional Screening, Parental Depression	Support	Work with IDHS, ISBE, DCFS, HFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services to ensure that programs that provide early care and education services are aware of and know how to access mental health consultation and treatment providers in order to support both staff members and young children and their families.
Parental Depression	Policy	Examine, with the ELC, whether it is appropriate and feasible to conduct maternal/paternal depression screenings in all early care and education programs who do not currently do so and incorporate screenings into programs as appropriate.
Parental Depression	Policy	Identify or develop, with the ELC, new models for delivering treatment for depression to parents that capitalize on the unique connections early care and education programs have with families while overcoming structural barriers to depression treatment.

APPENDIX D

Health Issue	Category	Recommendation
Parental Depression	Training	Work with the ELC, ICAAP, Erikson Institute, the Ounce Institute, INCCRRA, and other Illinois early childhood mental health and training experts to identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
Parental Depression	Support	Work with the ELC to research the possibility of extending the services provided by the University of Illinois at Chicago Perinatal Consultation Line to early care and education providers. If services cannot be extended, consider establishing a "warm line" that can provide training resources, tools to help with screening and referral, and telephone consultation for providers.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Work with the ELC to create a set of developmentally informed and culturally responsive policies and procedures for programs that work with young children exposed to trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICAAP, Erikson Institute, the Ounce of Prevention Fund, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood mental health and trauma experts, along with INCCRRA, to review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICAAP, Erikson Institute, the Ounce of Prevention Fund, and other Illinois early childhood mental health and training experts, along with INCCRRA, to create a training on self-care to be available to early care and education staff members to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.

Illinois Chapter of the American Academy of Pediatrics (ICAAP)

Health Issue	Category	Recommendation
Parental Depression	Training	Work with ICMHP, the ELC, Erikson Institute, the Ounce Institute, INCCRRA, and other Illinois early childhood mental health and training experts to identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, Erikson Institute, the Ounce of Prevention Fund, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood

APPENDIX D

Health Issue	Category	Recommendation
		mental health and trauma experts, along with INCCRRA, to review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, Erikson Institute, the Ounce of Prevention Fund, and other Illinois early childhood mental health and training experts, along with INCCRRA, to create a training on self-care to be available to early care and education staff members (if such a training does not currently exist) to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.

Illinois Childhood Trauma Coalition (ICTC)

Health Issue	Category	Recommendation
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Work with the ELC to create a set of developmentally informed and culturally responsive policies and procedures for programs that work with young children exposed to trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICMHP, ICAAP, Erikson Institute, the Ounce of Prevention Fund, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood mental health and trauma experts, along with INCCRRA, to review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICMHP, ICAAP, Erikson Institute, the Ounce of Prevention Fund, and other Illinois early childhood mental health and training experts, along with INCCRRA, to create a training on self-care to be available to early care and education staff members to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.

Illinois dental colleges

Health Issue	Category	Recommendation
Oral Health	Policy	Provide financial incentives and scholarships to dental students committed to serving pregnant women and young children in linguistically isolated and medically underserved areas.

APPENDIX D

Illinois Early Hearing Detection and Intervention Program (EHDI)

Health Issue	Category	Recommendation
Physical Health Screening: Hearing	Policy	Partner with the Illinois EHDI program and its ECHO Initiative to develop a standardized hearing screening protocol for early care and education programs serving children ages zero to three years.
Physical Health Screening: Hearing	Training	Partner with IDPH to develop and provide standardized training, in addition to their current training, to allow for certification and recertification of hearing screeners to screen children zero to three years old.

Illinois General Assembly

Health Issue	Category	Recommendation
Oral Health	Policy	Allocate sufficient funding to effectively implement Public Act 096-0757, which states that HFS shall establish an educational loan repayment assistance program for dentists, dental specialists, and dental hygienists who practice in designated shortage areas in Illinois and serve mostly Medicaid and CHIP clients.

Illinois Network of Child Care Resource and Referral Agencies (INCCRRA)

Health Issue	Category	Recommendation
Parental Depression	Training	Work with the ELC, ICMHP, ICAAP, Erikson Institute, the Ounce Institute, and other Illinois early childhood mental health and training experts to identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
Physical Health Screening: Vision	Training	Work with IDHS, IDPH, and ISBE to provide training for early childhood care providers and educators on vision and eye health, signs of vision problems in children, and state-wide guidelines for finding assistance in addressing the vision health of children ages three to five.
Physical Health Screening: Hearing	Training	Work with IDHS, ISBE and IDPH to provide training for early care and education providers on auditory health, signs of hearing problems in children, and statewide guidelines for finding assistance in addressing the auditory health of children ages zero to five.
SIDS, SBS, and Product Safety	Training	Update SIDS online training at least once every three years or whenever a significant change in the AAP recommendations is announced.

APPENDIX D

Health Issue	Category	Recommendation
SIDS, SBS, and Product Safety	Training	Update the online SBS class to include suggestions for handling provider stress and help on recognizing the signs and symptoms of TBI and to update that training whenever a significant change in the reasearch is announced by the AAP.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, ICAAP, Erikson Institute, the Ounce of Prevention Fund, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood mental health and trauma experts review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, ICAAP, Erikson Institute, the Ounce of Prevention Fund, and other Illinois early childhood mental health and training experts to create a training on self-care to be available to early care and education staff members to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.

Illinois State Board of Education (ISBE)

Health Issue	Category	Recommendation
Chronic Health Conditions	Policy	Extend 89 Illinois Administrative Code §407.250(c)(9) to require that all early care and education providers they regulate keep an updated medical action plan on file for any child with a chronic illness.
Chronic Health Conditions	Policy	Require that all early care and education providers they regulate provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms.
Chronic Health Conditions	Policy	Consider amending the Care of Students with Diabetes Act 105 ILCS 145/10 and DCFS should amend the Licensing Standards for centers §407.310(a)(3) to extend application of the Diabetes Care Act requirements to center and school-based programs.
Chronic Health Conditions	Policy	Consider amending the undesignated epinephrine auto-injector provisions in 105 ILCS 5/22-30 to allow certain early care and education settings to stock undesignated epinephrine auto-injectors.
Chronic Health Conditions	Training	Make available a delegated care aide (105 ILCS 145/25) training for all early care and education providers serving children with diabetes and additionally offer training on use of an EpiPen.
Immunizations	Information	Distribute information about the IDPH's immunization information number (800-526-4372) to all families.
Immunizations	Information	Provide information regarding primary care and medical home options for families with young children.

APPENDIX D

Health Issue	Category	Recommendation
Developmental and Social-Emotional Screening	Policy	Require social-emotional screening in programs that currently require regular developmental screening.
Developmental and Social-Emotional Screening	Policy	Explore the possibility of Medicaid reimbursement for developmental and social-emotional screening for early care and education programs who are not Medicaid providers.
Developmental and Social-Emotional Screening	Policy	Issue guidance to LEAs, CFCs, and early care and education programs on best practice Child Find activities that include monthly Child Find opportunities, social-emotional screening, and utilization of the MOU and screening resource guide.
Developmental and Social-Emotional Screening	Training	Offer training on social-emotional screening as regularly as training on developmental screening to early childhood providers and Child Find screening teams.
Developmental and Social-Emotional Screening	Training	Ensure that all training on developmental and social-emotional screening includes how to talk with parents about concerns and delays and how to use the MOUs and resource guide developed by the Special Education Subcommittee as well as how to use guidelines on best practices for referral, feedback, and lines of communication.
Developmental and Social-Emotional Screening; Parental Depression; Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.
Developmental and Social-Emotional Screening	Information	Distribute the MOUs and resource guide developed by the Special Education Subcommittee to all early care and education programs.
Developmental and Social-Emotional Screening	Information	When developed, disseminate guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Developmental and Social-Emotional Screening	Information	Ensure that handbooks and guidelines for parents that outline parent's rights and program responsibilities are updated when needed, widely distributed to early care and education programs, available at all trainings on developmental and social-emotional screening, and that the links on their websites to handbooks and guidelines for parents are visible and easily found.
Obesity Prevention	Training	Ensure that a training is created and available for early care and education providers on obesity prevention. The training should align with new requirements in 89 Illinois Administrative Code Rule 407 and include how to talk with families and parents about obesity and changes in child care menus, curriculum, and environments.
Obesity Prevention	Training	Ensure that a training is created and available for families and parents through early childhood programs on obesity prevention in early childhood including importance of regular physical activity, nutrition education, cooking, etc.
Obesity Prevention	Training	Ensure that a training is created and available for children enrolled in early childhood programs to expose them to the importance of regular physical activity, nutrition education, cooking, etc.
Oral Health	Policy	Develop an incentive or funding requirement for programs to demonstrate a collaborative

APPENDIX D

Health Issue	Category	Recommendation
		relationship(s) with local dental or primary care provider (e.g. an MOU).
Oral Health	Training	Ensure that all early childhood and education program staff have knowledge of: the oral health risk factors for pregnant women and children ages zero to five; best practices around nutrition, water consumption and brushing requirements as outlined by CFOC and the American Academy of Pediatric Dentists, and the importance of establishing a dental home by age one and understand how to help families access a dental home**.**
Oral Health	Information	Promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice.
Oral Health	Information	Partner with INCCRRA to promote regular (e.g., quarterly) dissemination to early care and education staff of an up-to-date health provider list that includes 1) pediatric dentists and 2) primary care physicians that have been trained through *Bright Smiles from Birth*, an oral health education program for primary care providers.
Parental Depression	Policy	Require that persons working with infants and toddlers in early childhood systems receive training on the effects of parental depression.
Parental Depression	Policy	Require that all early care and education programs that already screen for maternal/paternal depression have protocols in place for immediate referral should there be severe indications of depression or suicide ideation.
Parental Depression	Information	Disseminate information on maternal and paternal depression and the impact on child development to early care and education providers.
Physical Health Screening: Vision	Training	Work with INCCRRA to provide training for early childhood care providers and educators on vision and eye health, signs of vision problems in children, and state-wide guidelines for finding assistance in addressing the vision health of children ages three to five.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Policy	Require that persons working in early care and education programs receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.
Trauma, Child Abuse and Neglect, and Domestic Violence	Support	Extend mental health consultation services to staff members as a resource to help manage their emotional well-being in the event of a traumatic event experienced in the early care and education setting or within the community where the program is located.
Trauma, Child Abuse and Neglect, and Domestic Violence	Information	Promote state-wide dissemination of ICTC's public messaging campaign *Look Through Their Eyes*.
Trauma, Child Abuse and Neglect, and Domestic Violence	Information	Promote state-wide dissemination of fact sheets from ICTC and Strengthening Families Illinois on trauma (including information on child abuse and neglect and domestic violence) and promoting protective factors to early care and education providers, home visitors and EI providers for their own education and for distribution to staff and families.

APPENDIX D

Governor's Office of Early Childhood Development (OECD)

Health Issue	Category	Recommendation
Obesity Prevention	Information	In partnership with IDPH, ensure the creation and availability of public education (e.g., through a media campaign, published fact sheets, newsletter content) to raise awareness about the early origins of childhood obesity, the short- and long-term effects of obesity on children ages zero to eight, and the role that early care and education providers and settings can (and should) play in obesity prevention.

Ounce Institute

Health Issue	Category	Recommendation
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, ICAAP, Erikson Institute, the National Center on Domestic Violence, Trauma and Mental Health and other Illinois early childhood mental health and trauma experts, along with INCCRRA, review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse and Neglect, and Domestic Violence	Training	Work with ICTC, ICMHP, ICAAP, Erikson Institute, and other Illinois early childhood mental health and training experts, along with INCCRRA, to create a training on self-care to be available to early care and education staff members (if such a training does not currently exist) to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.
Parental Depression	Training	Work with the ELC, ICMHP, ICAAP, Erikson Institute, INCCRRA, and other Illinois early childhood mental health and training experts to identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.

APPENDIX E

Recommendations by Category

Policy

Health Issue	Agency/Organization	Recommendation
Chronic Health Conditions	DCFS	Extend 89 Illinois Administrative Code §407.250(c)(9) to require that all child care providers keep an updated medical action plan on file for any child with a chronic illness.
Chronic Health Conditions	DCFS	Amend the Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to require that center-, home-, and school-based early care and education programs update each child's Certificate of Health Examination annually.
Chronic Health Conditions	DCFS	Amend Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to require that all early care and education systems provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms. Where needed, these programs should also provide families with a "general medical action plan" for children with chronic health needs to complete with their medical provider (Appendix F, sample "Medical Report" and Appendix G, sample "General Medical Action Plan").
Chronic Health Conditions	DCFS	Consider amending the Licensing Standards for centers §407.310(a)(3) to extend application of the Diabetes Care Act requirements to center and school-based programs.
Chronic Health Conditions	DCFS	Consider amending the Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to allow certain early care and education settings to stock undesignated epinephrine auto-injectors.
Chronic Health Conditions	IDHS, ISBE	Require all early care and education providers that they regulate keep an updated medical action plan on file for any child with a chronic illness.
Chronic Health Conditions	IDHS, ISBE	Require that all early care and education providers that they regulate provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms. Where needed, these programs should also provide families with a "general medical action plan" for children with chronic health needs to complete with their medical provider (Appendix F, sample "Medical Report" and Appendix G, sample "General Medical Action Plan").
Chronic Health Conditions	IDPH	Amend the Illinois Child Health Examination Code §665.140(e) for school-based child care to require that center-, home-, and school-based early care and education programs update each child's Certificate of Health Examination annually.
Chronic Health Conditions	IDPH	Amend the Illinois Child Health Examination Code §665.140(e) for school-based child care to require that all early care and education systems provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms. Where needed, these programs should also provide families with a "general medical action plan" for children with chronic health needs to complete with their medical provider (Appendix F, sample "Medical Report" and Appendix G, sample "General Medical Action Plan").
Chronic Health Conditions	ISBE	Consider amending the undesignated epinephrine auto-injector provisions in 105 ILCS 5/22-30 to allow certain early care and education settings to stock undesignated epinephrine auto-injectors.
Chronic Health	ISBE	Consider amending the Care of Students with Diabetes Act 105 ILCS 145/10 to extend application of

APPENDIX E

Health Issue	Agency/Organization	Recommendation
Conditions		the Diabetes Care Act requirements to center and school-based programs.
Immunizations	DCFS	Amend the Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to require that center-, home-, and school-based early care, education and intervention programs update each child's Certificate of Health Examination annually.
Immunizations	IDPH	Amend the Illinois Child Health Examination Code §665.140(e) for school-based programs administered by ISBE to require that center-, home-, and school-based early care, education and intervention programs update each child's Certificate of Health Examination annually.
Developmental and Social-Emotional Screening	IDHS, ISBE, DCFS, HFS	Require social-emotional screening in programs that currently require regular developmental screening
Developmental and Social-Emotional Screening	IDHS, ISBE	Where not feasible to administer developmental and/or social-emotional screening, ensure that children are screened through Child Find or pediatricians through information and support to parents.
Developmental and Social-Emotional Screening	IDHS, ISBE, DCFS, HFS	Explore the possibility of Medicaid reimbursement for developmental and social-emotional screening for early care and education programs who are not Medicaid providers.
Developmental and Social-Emotional Screening	ICMHP, ELC	Develop guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Developmental and Social-Emotional Screening	ISBE	Issue guidance to LEAs, CFCs, and early care and education programs on best practice Child Find activities that include monthly Child Find opportunities, social-emotional screening, and utilization of the MOU and screening resource guide developed by the Special Education Subcommittee of the Systems Integration and Alignment Subcommittee of the ELC.
Developmental and Social-Emotional Screening	DCFS	Require developmental (including social-emotional screening) in both 406 licensing standards for licensed family child care providers and 407 licensing standards for center based child care providers.
Immunizations; Developmental and Social-Emotional Screening; Physical Health Screening: Lead; Physical Health Screening: Vision	ELC	Recommend through the Data, Research and Evaluation Committee that developmental and social-emotional, vision, and lead screenings as well as immunization documentation be included in the Unified Early Childhood Data System.
Obesity Prevention, Oral Health	DCFS	Update 89 Illinois Administrative Code Rule 406 to align with the nutrition, physical activity, and screen time standards as well as the oral health and hygiene standards in Rule 407.
Obesity Prevention	DCFS	Amend 89 Illinois Administrative Code Rule 407 to include the recommendations from the Systems Integration and Alignment Committee, Health Subcommittee that were previously submitted, but

APPENDIX E

Health Issue	Agency/Organization	Recommendation
		not accepted, including: a. Programs should avoid serving concentrated sweets, such as candy, cupcakes, donuts, cookies, and other sugary foods. b. Children ages 12 months or older should participate in 60 minutes of age-appropriate moderate to vigorous physical activity per day. For children ages three (36 months) and older, at least 30 of the 60 minutes shall be structured and guided moderate to vigorous physical activity; the remainder of the physical activity may be concurrent with other active play, learning, and movement activities. i. Structured and guided physical activity shall be facilitated by teachers and/or child care providers and shall promote basic movement, creative movement, motor skills development, and general coordination. ii. Children attending a program less than six hours shall be scheduled to participate in a proportionate amount of such activities. c. Children attending a program less than six hours shall be scheduled to participate in at least one occasion of age-appropriate outdoor time. d. When screen time media is used, whether interactive or passive, it should be free of food and beverage advertising and brand placement.
Oral Health	DCFS	Amend Rule 407 to include the recommendations from the Systems Integration and Alignment Committee, Health Subcommittee that were previously submitted, but not accepted, including: a. Require early care and education programs to encourage parents to establish a dental home for their child within six months after the first tooth erupts or by one year of age, whichever is earlier. b. Starting at birth, early care and education staff should clean an infant's gums using water and a soft infant toothbrush or cloth preferably after meals. c. Require that all children with teeth should brush or have their teeth brushed at least once during the hours the child is in care if care is provided for five or more hours per day, preferably after a meal or a snack. The staff should either brush the child's teeth or supervise as the child brushes his/her own teeth and brushing should be supervised until the child can reliably rinse and spit out excess toothpaste (usually at six years of age). The caregiver/teacher should teach the child the correct method of tooth brushing when the child is capable of doing this activity. d. Extend the current standard in Rule 407, Section 407.240 ("Evening, Night, Weekend, and Holiday Care") to all licensed child care centers, regardless of center business hours and days of operation: Each child shall have an individual toothbrush furnished either by the center or the child's parents. e. Require that programs should not allow the sharing of a toothbrush with a child due to the risk of promoting early colonization of the infant oral cavity with Streptococcus mutans, bacteria that causes early childhood caries. f. Require that staff use a "smear" of toothpaste to brush the teeth of a child less than two years of age. For the two to five year old, staff should dispense a "pea-size" amount of toothpaste.

APPENDIX E

Health Issue	Agency/Organization	Recommendation
		g. Since all public water systems in Illinois are optimally fluoridated, children should drink water from the tap in order to reduce the risk of dental caries and tooth decay.
Oral Health	IDHS, ISBE	Develop an incentive or funding requirement for programs to demonstrate a collaborative relationship(s) with local dental or primary care provider (e.g., an MOU)
Oral Health	Illinois General Assembly	Allocate sufficient funding to effectively implement Public Act 096-0757 which states that HFS shall establish an educational loan repayment assistance program for dentists, dental specialists, and dental hygienists who practice in designated shortage areas in Illinois and serve mostly Medicaid and CHIP clients.
Oral Health	Illinois dental colleges	Provide financial incentives and scholarships to dental students committed to serving pregnant women and young children in linguistically isolated and medically underserved areas.
Parental Depression	IDHS, ISBE, DCFS, HFS	Require that persons working with infants and toddlers in early childhood systems receive training on the effects of parental depression.
Parental Depression	IDHS, ISBE, DCFS, HFS	Require that all early care and education programs that already screen for maternal/paternal depression have protocols in place for immediate referral should there be severe indications of depression or suicide ideation.
Parental Depression	ELC (with ICMHP)	Examine whether it is appropriate and feasible to conduct maternal/paternal depression screenings in all early care and education programs who do not currently do so and incorporate screenings into programs as appropriate.
Parental Depression	ELC (with ICMHP)	Identify or develop new models for delivering treatment for depression to parents that capitalize on the unique connections early care and education programs have with families while overcoming structural barriers to depression treatment. The feasibility of utilizing these models in Illinois should be evaluated and strategies to finance and implement them at scale should be developed.
Physical Health Screening: Lead	IDPH	Amend the Lead Poisoning Prevention Act P.A. 94-879 §7(1) to require all early care, education and intervention programs to collect evidence of lead screenings or tests in accordance with the IDPH Childhood Lead Risk Assessment Questionnaire guidelines.
Physical Health Screening: Lead	IDHS	Explicitly list lead poisoning in 89 Illinois Administrative Code §500, Appendix E "Medical Conditions Resulting in High Probability of Developmental Delay" to guarantee children with lead poisoning automatic eligibility for EI services.
Physical Health Screening: Vision	IDPH	Establish an additional certification and recertification option for technicians to conduct vision screenings for children ages three to five only.
Physical Health Screening: Vision, Hearing	IDPH	Authorize early childhood training entities to conduct trainings that qualify for IDPH certification and recertification vision and hearing screening option for children ages three to five.
Physical Health Screening: Vision	IDPH	Revise vision screening administrative codes (Vision Screening Section 685) to follow the screening protocols recommended and continually assessed by the National Center for Children's Vision and Eye Health.
Physical Health Screening: Vision,	IDPH	Establish or authorize through another entity an Early Childhood Vision Screening Resource Center and an Early Childhood Hearing Screening Resource Center (partnering with EHDI and ECHO) to

APPENDIX E

Health Issue	Agency/Organization	Recommendation
Hearing		provide ongoing skill supports and technical assistance for certified early childhood vision and hearing screeners.
Physical Health Screening: Hearing	IDPH	Partner with the Illinois EHDI program and its ECHO Initiative to develop a standardized hearing screening protocol for early care and education programs serving children ages zero to three years.
Physical Health Screening: Hearing	IDPH	Establish an additional certification and recertification option for technicians to conduct hearing screenings utilizing OAE technology for children ages zero to three years.
SIDS, SBS, and Product Safety	DCFS	Include deaths of a minor child in a licensed or licensed-exempt child care center or home in the CDRT system.
SIDS, SBS, and Product Safety	DCFS	Link directly with the Consumer Product Safety Commission's recall list so that it is always complete and accurate and DCFS should require licensed providers to sign up for alerts from the CPSC.
SIDS, SBS, and Product Safety	DCFS	Develop a consistent policy for reviewing equipment safety at every site visit including verification of supporting documentation that products meet current federal manufacturing guidelines set forth by the ASTM.
SIDS, SBS, and Product Safety	DCFS	Amend 89 Illinois Administrative Code Rules 407 and 406 to include language in licensing to require that products be used as the manufacturer intended in the instructions.
Trauma, Child Abuse & Neglect, and Domestic Violence	ELC, ICTC, ICMHP	Jointly create a set of developmentally informed and culturally responsive policies and procedures for programs that work with young children exposed to trauma.
Trauma, Child Abuse & Neglect, and Domestic Violence	IDHS, ISBE, DCFS, HFS	Have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.
Trauma, Child Abuse & Neglect, and Domestic Violence	IDHS, ISBE, DCFS, HFS	Require that persons working in early care and education programs receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.

Training

Health Issue	Agency/Organization	Recommendation
Chronic Health Conditions	DCFS	Provide early care and education providers with training in the use of action plans, identifying the first signs of allergic reactions or chronic health issues and communicating sensitively to parents about common chronic health issues and appropriate follow-up care.
Chronic Health Conditions	IDHS	Provide early care and education providers with training in the use of action plans, identifying the first signs of allergic reactions or chronic health issues and communicating sensitively to parents

APPENDIX E

Health Issue	Agency/Organization	Recommendation
		about common chronic health issues and appropriate follow-up care.
Chronic Health Conditions	Gateways to Opportunity	Expand the "Welcoming Every Child" training to include more comprehensive information for using action plans to support children with chronic health issues.
Chronic Health Conditions	ISBE	Make available a delegated care aide (105 ILCS 145/25) training for all early care and education providers serving children with diabetes and additionally offer training on use of an EpiPen.
Immunizations	IDHS, HFS	Ensure that all early care and education program staff have knowledge of the importance of establishing a medical home and accessing immunizations, as well as adhering to the CDC's recommended immunization schedule for young children.
Developmental and Social-Emotional Screening	IDHS, ISBE, DCFS, HFS	Offer training on social-emotional screening as regularly as training on developmental screening to early care and education providers and Child Find screening teams.
Developmental and Social-Emotional Screening	ISBE, IDHS, DCFS	Ensure that all training on developmental and social-emotional screening includes how to talk with parents about concerns and delays and how to use the MOUs and resource guide developed by the Special Education Subcommittee as well as how to use guidelines (when developed) on best practices for referral, feedback, and lines of communication.
Obesity Prevention	ISBE, IDHS	Ensure that a training is created and available for early care and education providers on obesity prevention. This training should align with new requirements in 89 Illinois Administrative Code Rule 407 and should include how to talk to parents about obesity and changes in child care menus, curriculum, and environments
Obesity Prevention	ISBE, IDHS	Ensure that a training is created and available for families and parents through early childhood programs on obesity prevention in early childhood including importance of regular physical activity, nutrition education, cooking, etc.
Obesity Prevention	ISBE, IDHS	Ensure that a training is created and available for children enrolled in early childhood programs to expose them to the importance of regular physical activity, nutrition education, cooking, etc.
Oral Health	ISBE, IDHS	Ensure that all early childhood and education program staff have knowledge of: the oral health risk factors for pregnant women and children ages zero to five; best practices around nutrition, water consumption and brushing requirements as outlined by CFOC and the American Academy of Pediatric Dentists, and the importance of establishing a dental home by age one and understand how to help families access a dental home**.**
Parental Depression	ELC, ICMHP, ICAAP, Erikson Institute, the Ounce Institute, INCCRRA	Identify or develop training (if such a training does not currently exist) for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
Physical Health Screening: Lead	Gateways to Opportunity	Adapt the IDPH Lead Program's visual lead risk assessment training for early care, education and intervention providers who perform regular home visits in EI or home-based EHS programs.
Physical Health Screening: Vision	IDHS, ISBE, IDPH (with INCCRRA)	Provide training for early childhood care providers and educators on vision and eye health, signs of vision problems in children, and state-wide guidelines for finding assistance in addressing the vision

APPENDIX E

Health Issue	Agency/Organization	Recommendation
		health of children ages three to five.
Physical Health Screening: Vision	IDPH	Develop training for early care and education providers on the state vision screening mandates and disseminate this training through IDHS, ISBE, and INCCRRA.
Physical Health Screening: Hearing	IDPH	Partner with EHDI and the ECHO to develop and provide standardized training, in addition to their current training, to allow for certification and recertification of hearing screeners to screen children zero to three years old.
Physical Health Screening: Hearing	IDHS, ISBE, IDPH (with INCCRRA)	Provide training for early care and education providers on auditory health, signs of hearing problems in children, and statewide guidelines for finding assistance in addressing the auditory health of children zero to five years old
Physical Health Screening: Hearing	IDPH	Develop a standardized training and curricula, in addition to the current preschool resources through school-age training, to allow for certification and recertification of vision and hearing screeners for all early care and education programs zero to three and zero to five years.
SIDS, SBS, and Product Safety	INCCRRA	Update the SIDS online training at least once every three years or whenever a significant change in the AAP recommendations is announced.
SIDS, SBS, and Product Safety	INCCRRA	Update the SBS online class to include suggestions for handling provider stress and help on recognizing the signs and symptoms of TBI and to update that training whenever a significant change in the reasearch is announced by the AAP.
SIDS, SBS, and Product Safety	Home visiting models/curricula	Require training for home visitors rather than recommend.
Trauma, Child Abuse & Neglect, and Domestic Violence	ICTC, ICMHP, ICAAP, Erikson Institute, Ounce Institute, INCCRRA	Jointly review current trauma trainings and establish a training protocol of the critical components of trauma training needed for staff working with young children and families in early childhood systems. These organizations should ensure that the training protocol is culturally responsive.
Trauma, Child Abuse & Neglect, and Domestic Violence	ICTC, ICMHP, ICAAP, Erikson Institute, Ounce Institute, INCCRRA	Jointly create a training on self-care to be available to early care and education staff members (if such a training does not currently exist) to help them manage vicarious or second hand trauma experienced within their work environment as well as stressors in their own lives so they can better support young children and their families.
Trauma, Child Abuse & Neglect, and Domestic Violence	DCFS	Revise the current mandated reporter training to include more comprehensive information on how to recognize signs of abuse and neglect, understand the impact of abuse and neglect on brain and child development, and respond if an instance of abuse or neglect is revealed.

Support

Health Issue	Agency/Organization	Recommendation
Developmental and Social-Emotional	IDHS, ISBE, DCFS, HFS	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.

APPENDIX E

Health Issue	Agency/Organization	Recommendation
Screening; Parental Depression; Trauma, Child Abuse & Neglect, and Domestic Violence		
Parental Depression	HFS	Disseminate a list of behavioral health services available through Medicaid, including instructions for accessing these services, to the state agencies for dissemination to all providers. This resource should be available to both staff and families.
Parental Depression	ELC (with ICMHP)	Research the possibility of extending the services provided by the University of Illinois at Chicago Perinatal Consultation Line to early care and education providers (it is currently targeted toward medical providers). If services cannot be extended, consider establishing a "warm line" that can provide training resources, tools to help with screening and referral, and telephone consultation for providers.
SIDS, SBS, and Product Safety	DCFS	Expand the network of licensing representatives so that it includes Product Safety Inspectors.
Trauma, Child Abuse & Neglect, and Domestic Violence	DCFS	Provide early care and education providers with automatic access to the SPD of service agencies and programs throughout Illinois so that providers can locate mental health resouces in their communities to support young children and families.
Trauma, Child Abuse & Neglect, and Domestic Violence	IDHS, ISBE, DCFS, HFS	Extend mental health consultation services to staff members as a resource to help manage their emotional well-being in the event of a traumatic event experienced in the early care and education setting or within the community where the program is located.

Information

Health Issue	Agency/Organization	Recommendation
Chronic Health Conditions	HFS	Develop and provide information regarding primary care, medical home, and insurance coverage options to DCFS, IDHS, ISBE, and OECD to disseminate to families with young children in early care and education programs.
Chronic Health Conditions	IDPH	Develop medical action plan guides for DCFS, ISBE, and IDHS to distribute to their programs to show parents how to talk to health care providers about action plans and how to communicate with early care and education providers about their children's chronic health needs.
Immunizations	IDPH	Provide information about immunizations and where to get immunizations for families with young children to state agencies for dissemination to all early care and education providers. This resource should be available to both staff and families.
Immunizations	IDHS, HFS, ISBE	Distribute information about IDPH's immunization information number (800-526-4372) to all

APPENDIX E

Health Issue	Agency/Organization	Recommendation
		families.
Immunizations	IDHS, ISBE	Provide information regarding primary care and medical home options for families with young children.
Developmental and Social-Emotional Screening	ISBE, IDHS, DCFS	Distribute the MOUs and resource guide developed by the Special Education Subcommittee to all early care and education programs and make it available in all trainings on developmental and social-emotional screening.
Developmental and Social-Emotional Screening	ISBE, IDHS, DCFS	Disseminate guidelines for best practices in referral, feedback, and lines of communication between parents, early care and education providers, and medical providers.
Developmental and Social-Emotional Screening	ISBE, IDHS, DCFS	Ensure that handbooks and guidelines for parents that outline parent's rights and program responsibilities are updated when needed, widely distributed to early care and education programs and available at all trainings on developmental and social-emotional screening.
Developmental and Social-Emotional Screening	ISBE, IDHS, DCFS	Ensure the links on their websites to handbooks and guidelines for parents are visible and easily found.
Obesity Prevention	OECD (with IDPH)	Ensure the creation and availability of public education to raise awareness about the early origins of childhood obesity, the short- and long-term effects of obesity on children ages zero to eight, and the role that early care and education providers and settings can (and should) play in obesity prevention.
Oral Health	IDHS, ISBE, HFS, DCFS	Promote state-wide dissemination of public health messaging related to evidenced-based oral health best practice to all early care and education providers.
Oral Health	HFS, IDHS, ISBE (in partnership with INCCRRA)	Promote regular dissemination to early care and education staff of an up-to-date health provider list that includes 1) pediatric dentists and 2) primary care physicians that have been trained through *Bright Smiles from Birth*.
Parental Depression	IDHS, ISBE, DCFS, HFS	Disseminate information on maternal and paternal depression and the impact on child development to these providers.
Physical Health Screening: Lead	IDPH	Develop and distribute materials to all early care and education providers explaining the signs of lead presence in the home as well as early symptoms of lead exposure.
Physical Health Screening: Hearing	IDPH	Disseminate information on the state hearing screening mandates to IDHS, ISBE, DCFS, and any other state or city agency that is responsible for overseeing or licensing organizations or programs that provide early care and education services.
Trauma, Child Abuse & Neglect, and Domestic Violence	IDHS, ISBE, DCFS, HFS	Promote state-wide dissemination of ICTC's public messaging campaign *Look Through Their Eyes*.
Trauma, Child Abuse & Neglect, and Domestic Violence	IDHS, ISBE, DCFS, HFS	Promote state-wide dissemination of fact sheets from ICTC and Strengthening Families Illinois on trauma (including information on child abuse and neglect and domestic violence) and promoting protective factors to early care and education providers, home visitors and EI providers for their own education and for distribution to staff and families.

APPENDIX F

Recommendations by Top Priority (as identified by each health issue)

Chronic Health Conditions

Agency/Organization	Category	Recommendation
DCFS, IDHS, ISBE	Policy	Extend 89 Illinois Administrative Code §407.250(c)(9) to require that all child care providers keep an updated medical action plan on file for any child with a chronic illness. Extend this to all early care and education systems that these state agencies regulate, including EI and home visiting programs.
IDPH, DCFS, IDHS, ISBE	Policy	Amend the Illinois Child Health Examination Code §665.140(e) for school-based child care and Licensing Standards for centers §407.310(a)(3) and home-based child care §406.14(c)(1) to require that all early care and education systems provide a general "medical report" to families to complete upon enrollment, along with annual opportunities to update these forms. Extend this requirement to all early care and education systems that these state agencies regulate, including EI and home visiting programs. Where needed, these programs should also provide families with a "general medical action plan" for children with chronic health needs to complete with their medical provider (Appendix G, sample "Medical Report" and Appendix H, sample "General Medical Action Plan").
DCFS, IDHS	Training	Provide early care and education providers with training in the use of action plans, identifying the first signs of allergic reactions or chronic health issues and communicating sensitively to parents about common chronic health issues and appropriate follow-up care.

Immunizations

Agency/Organization	Category	Recommendation
IDHS, HFS	Training	Ensure that all program staff, but particularly family support staff and early childhood staff, have knowledge of the importance of establishing a medical home and accessing immunizations, as well as adhering to the CDC's recommended immunization schedule for young children.
IDHS, ISBE, HFS	Information	Distribute information about immunizations and where to get immunizations for families with young children to state agencies for dissemination to all early care and education providers. This resource should be available to both staff and families.

Developmental and Social-Emotional Screening

Agency/Organization	Category	Recommendation
IDHS, ISBE, DCFS, HFS	Policy	Require social-emotional screening in programs that currently require regular developmental screening.
ISBE	Policy	Issue guidance to LEAs, CFCs, and early care and education programs on best practice Child Find activities that include monthly Child Find opportunities, social-emotional screening, and utilization of the MOU and screening resource guide developed by the Special Education Subcommittee of the

APPENDIX F

Agency/Organization	Category	Recommendation
		Systems Integration and Alignment Subcommittee of the ELC.
IDHS, ISBE, DCFS, HFS	Training	Offer training on social-emotional screening as regularly as training on developmental screening to early care and education providers and Child Find screening teams

Obesity Prevention

Agency/Organization	Category	Recommendation
ISBE, IDHS	Training	Ensure that a training is created and available for early care and education providers on obesity prevention. This training should align with new requirements in Rule 407.
ISBE, IDHS	Training	Ensure that a training is created and available to early care and education providers on how to talk with families and parents about obesity and changes in child care menus, curriculum, and environments.
ISBE, IDHS	Training	Ensure that a training is created and available for families and parents through early childhood programs on obesity prevention in early childhood including importance of regular physical activity, nutrition education, cooking, etc.

Oral Health

Agency/Organization	Category	Recommendation
DCFS	Policy	Update 89 Illinois Administrative Rule 406 to align with the oral health and hygiene standards in Rule 407.
IDHS, ISBE	Training	Ensure that all early care and education program staff have knowledge of: the oral health risk factors for pregnant women and children ages zero to five; best practices around nutrition, water consumption and brushing requirements as outlined by CFOC and the American Academy of Pediatric Dentists; and the importance of establishing a dental home by age one and understand how to help families access a dental home.

Parental Depression

Agency/Organization	Category	Recommendation
ELC, ICMHP, ICAAP, Erikson Institute, Ounce Institute (along with INCCRRA)	Training	Identify or develop training for early care and education providers on maternal and paternal depression that includes the critical components of: effects of parental depression on child development; how to recognize signs and symptoms of depression; resources for treatment and support; and how to talk with parents about depression. Training should also include how to respond should staff suspect severe indications of depression or suicide ideation.
IDHS, ISBE, DCFS, HFS	Support	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.
ELC (along with ICMHP)	Policy	Identify or develop new models for delivering treatment for depression to parents that capitalize on the

APPENDIX F

Agency/Organization	Category	Recommendation
		unique connections early care and education programs have with families while overcoming structural barriers to depression treatment. The feasibility of utilizing these models in Illinois should be evaluated and strategies to finance and implement them at scale should be developed.

Physical Health Screening: Lead

Agency/Organization	Category	Recommendation
IDPH	Policy	Amend the Lead Poisoning Prevention Act P.A. 94-879 §7(1) to require all early care, education and intervention programs to collect evidence of lead screenings or tests in accordance with the IDPH Childhood Lead Risk Assessment Questionnaire guidelines.
Gateways to Opportunity	Training	Adapt the IDPH Lead Program's visual lead risk assessment training for early care, education and intervention providers who perform regular home visits in EI or home-based EHS programs.

Physical Health Screening: Vision

Agency/Organization	Category	Recommendation
IDPH	Policy	Establish an additional certification and recertification option for technicians to conduct vision screenings for children ages three to five only.
IDPH	Policy	Revise vision screening administrative codes (Vision Screening Section 685) to follow the screening protocols recommended and continually assessed by the National Center for Children's Vision and Eye Health.
IDPH (along with INCCRRA)	Training	Develop training for early care and education providers on the state vision screening mandates and disseminate this training through IDHS and ISBE.

Physical Health Screening: Hearing

Agency/Organization	Category	Recommendation
IDPH (along with EHDI/ECHO)	Policy	Develop a standardized hearing screening protocol for early care and education programs serving children ages zero to three years.
IDPH	Policy	Authorize early childhood training entities to conduct trainings that qualify for IDPH certification and recertification hearing screening option for children ages zero to three years as well as three to five years.

APPENDIX F

SIDS, SBS, and Product Safety

Agency/Organization	Category	Recommendation
DCFS	Policy	Include deaths of a minor child in a licensed or licensed-exempt child care center or home in the CDRT system.
DCFS	Policy	Link directly with the Consumer Product Safety Commission's recall list so that it is always complete and accurate and DCFS should require licensed providers to sign up for alerts from the CPSC.

Trauma, Child Abuse & Neglect, and Domestic Violence

Agency/Organization	Category	Recommendation
IDHS, ISBE, DCFS, HFS	Policy	Have Illinois early childhood mental health and trauma experts create a standard intake/enrollment protocol to include developmentally appropriate and culturally responsive questions regarding whether the child has experienced trauma.
IDHS, ISBE, DCFS, HFS	Policy	Require that early care and education staff receive a general introduction to trauma training that includes the effects of trauma on brain development and child development, how to recognize signs of trauma and how to talk with caregivers and children about trauma.
IDHS, ISBE, DCFS, HFS	Support	Ensure that mental health consultation is available to and accessed regularly by all early care and education program staff.

APPENDIX G

MEDICAL REPORT

Please PRINT all information and return to your child's Early Childhood Provider

Child's Name: _____ Date of Birth: ____/____/____

To ensure the safety of your child during activities throughout the day, it is important that your Early Childhood Providers are aware of any health conditions that may impact your child.

Please indicate with a check if any of the following apply to your child:

☐ Food Allergies: (Type) _____
☐ Other Allergies: (Type) _____
☐ Asthma
☐ Diabetes: ☐ Type 1 ☐ Type 2
☐ Seizures/Epilepsy
☐ Chronic Heart Condition
☐ Cystic Fibrosis
☐ Sickle Cell Disease
☐ Hearing Impairment
☐ Vision Impairment
☐ Lead Poisoning
☐ Other Medical Condition or Concern (please describe):_____
_____

☐ My child has **NO** allergies, medical condition, and/or does not take any medication during school hours.
☐ My child has witnessed or experienced violence in the home or in the community (please describe):
_____

☐ My child has experienced loss in the family (*e.g.*, death, incarceration, separation/divorce, deportation, loss of home) (please describe): _____

☐ My child has shown or experienced any of the following: excessive crying, anxiety, fear, aggression, tantrums, clinginess, nightmares, developmental regression (please describe): _____
_____

☐ My child has a primary healthcare provider *(e.g.*, doctor, nurse practitioner, physician assistant, *etc*.)
☐ My child has visited his/her primary healthcare provider in the past year. (If not, a checkup may be necessary to determine whether any of the above apply to your child.) *Date of last visit*: _____

For any medical condition or administration of medication identified above, please include an Action Plan with this form. An Action Plan is an essential tool for childcare providers. They provide a written roadmap detailing everyday steps to manage your child's medical condition as well as provide directions for avoiding triggers and recognizing and responding to medical emergencies. A sample "General Medical Action Plan" is attached to this form. Parents are encouraged to fill out this general form with their healthcare provider, or work with their healthcare provider to complete an Action Plan specifically tailored to their child's medical condition (e.g. Asthma Action Plan).

Parent Name _____ Date _____

Parent Signature _____

Phone Number _____ Email _____

APPENDIX H

GENERAL MEDICAL ACTION PLAN

Diagnosis (What is the illness or condition?)

_____

_____

Daily Care Needs (List all your child's medications and treatments here. Does your child administer his or her own medication? When should each medication or treatment be given?)

_____

_____

Triggers (Does anything trigger any of the symptoms you described above? What should your child avoid? (*e.g.*, food, drinks, animals, exercise))

_____

_____

Warning Signs (Are peak flows low? Is your child's skin red or irritated? Is your child in pain? Is your child scared, anxious, aggressive, or withdrawn? What symptoms would signal a medical emergency?)

_____

_____

Activity Level (When should your child not participate in recess or P.E.?)

_____

_____

Emergency Action Plan (What should you do if the child is not getting better? At what point should the child be taken to the hospital? What should a provider do until help arrives? Does your child have an emergency medication? Who should be called in the family?)

_____

_____

_____

_____

Contact Information (Names and telephone numbers to call if your child is sick. (*e.g.*, parents, healthcare providers, *etc*.)

_____

_____

Medical Provider signature_____**Date**_____

APPENDIX I

Sample Asthma Action Plan

Date: _____ **Asthma Medicine for** _____

Everyday Keep your child healthy.
Give **everyday medicine** when healthy or sick.

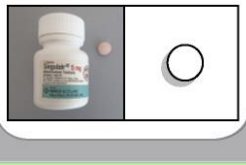
Your child is feeling good:
- No trouble breathing
- No cough or wheeze
- Sleeps well
- Can play as usual

Morning

Flovent
2 puffs with spacer

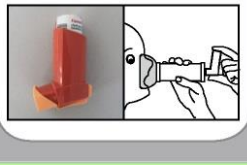
Night

Singulair
1 chewable tablet



and

Flovent
2 puffs with spacer



Sick Give **sick medicine and add everyday medicine.**
If not feeling better in 1 day, call your doctor.

Your child has **any** of these:
- Some trouble breathing
- Cough in the day or night
- Mild wheeze
- Feels tightness in chest

Albuterol
2 puffs with spacer

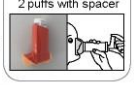
If needed,
give every 4 hours

and

Everyday

Morning

Flovent
2 puffs with spacer



Night

Singulair
1 chewable tablet

and

Flovent
2 puffs with spacer

Very sick The asthma is getting worse.
Give **sick medicine**. **Get help now!**

Your child has **any** of these:
- Breathing is hard and fast
- Can't stop coughing
- Ribs show when breathing
- Neck pulls in
- Can't talk or walk well

Albuterol
2 puffs with spacer

and

Call a doctor or 911
Go to the hospital

The H.E.L.P. Project Bellevue Hospital **Pediatric Clinic** **(212) 562-5524**